

**LANCASHIRE**  
***PRISON HEALTH NEEDS***  
***ASSESSMENT***  
**2011**

**HMYOI LANCASTER FARMS**

**HMP KIRKHAM**

**HMP PRESTON**

**HMP GARTH**

**HMP WYMOTT**

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# CONTENTS

|   | Page         |
|---|--------------|
| <b>ACKNOWLEDGEMENTS</b>                                     | <b>2</b>     |
| <b>1.0 INTRODUCTION</b>                                     | <b>7</b>     |
| <b>2.0 BACKGROUND TO HEALTH NEEDS ASSESSMENTS</b>           | <b>8-10</b>  |
| 2.1 What is a HNA?  | 8            |
| 2.2 Needs explained   | 9            |
| 2.3 Aims of HNA   | 9            |
| 2.4 Methodology   | 9-10         |
| <b>3.0 LANCASHIRE PRISON ESTATE</b>                         | <b>11-17</b> |
| 3.1 HMP Preston   | 11-12        |
| 3.2 HMP Garth   | 12-13        |
| 3.3 HMP Wymott  | 13-14        |
| 3.4 HMYOI Lancaster Farms                                   | 14           |
| 3.5 HMP Kirkham   | 15-17        |
| <b>4.0 PRISON POPULATION PROFILE</b>                        | <b>18-29</b> |
| 4.1 Age Profile   | 19-20        |
| 4.2 Ethnicity   | 20-23        |
| 4.3 Home  | 23-24        |
| 4.4 Prisoner status and length of stay                      | 24-26        |
| 4.5 Social Characteristics of sentenced prisoners           | 27           |
| 4.6 Impact of imprisonment on significant others and family | 28-29        |
| <b>5.0 EPIDEMIOLOGICAL NEEDS ASSESSMENT</b>                 | <b>30-61</b> |
| 5.1 Prevalence of Health Conditions                         | 30-31        |
| 5.2 Physical health   | 32           |
| 5.2.1 Minor Illnesses                                       | 32           |
| 5.2.2 Long Term Conditions                                  | 32-40        |
| 5.2.2.1 Epilepsy  | 32-33        |
| 5.2.2.2 Asthma  | 34           |
| 5.2.2.3 COPD  | 34-35        |
| 5.2.2.4 Diabetes  | 36-37        |
| 5.2.2.5 Coronary Vascular Disease                           | 38-39        |

|   |                |
|---|----------------|
| 5.2.2.6 Cancer  | 40             |
| 5.3 Communicable Diseases   | 41             |
| 5.3.1 Blood Borne Viruses – HIV, Hepatitis B and Hepatitis C                | 41             |
| 5.3.2 Sexually transmitted infections                                       | 42             |
| 5.3.3 Tuberculosis  | 42-43          |
| 5.3.4 Gastrointestinal disease  | 43             |
| 5.3.5 Influenza   | 43             |
| 5.4 Immunisation and Vaccination  | 43-44          |
| 5.5 Special Senses and Disability   | 44-45          |
| 5.6 Mental Health and Wellbeing   | 45             |
| 5.6.1 Policy  | 45-46          |
| 5.6.2 Prevalence Studies  | 46-50          |
| 5.7 Lifestyle / Risk Factors  | 51             |
| 5.7.1 Alcohol and Drug Misuse   | 51-54          |
| 5.7.2 Smoking   | 54-55          |
| 5.7.3 Obesity   | 55             |
| 5.7.4 Hypertension  | 55-56          |
| 5.7.5 Serum Cholesterol   | 56             |
| 5.8 Dental Health   | 56-57          |
| 5.9 Wellbeing   | 57             |
| 5.9.1 The Impact of Wellbeing   | 57-58          |
| Creating Supportive Environments  | 58-59          |
| 5.10 Palliative Care and End of Life  | 61             |
| <b>6.0 COMPARATIVE NEEDS ASSESSMENT</b>                                     | <b>62 – 98</b> |
| 6.1 Analysis  | 63-66          |
| 6.2 Health Care Services  | 66– 83         |
| 6.2.1 Effectiveness of services and Interventions                           | 66-67          |
| 6.2.2 Literature review of effective services, interventions and guidelines | 68             |
| 6.2.3 Physical Health   | 68-69          |
| 6.2.3.1 Long Term Conditions  | 69-71          |
| 6.2.3.2 Cancer  | 71             |
| 6.2.4 Communicable Diseases   | 72-74          |
| 6.2.5 Special Senses and Disability   | 75             |
| 6.2.6 Mental Health   | 75             |
| 6.2.7 Substance Misuse  | 75-77          |
| 6.2.8 Alcohol Misuse  | 78-79          |
| 6.2.9 Smoking   | 79-80          |
| 6.2.10 Obesity  | 80             |
| 6.2.11 Dental   | 81             |

|  |               |
|--|---------------|
| 6.2.12 Palliative and End of Life  | 81-82         |
| 6.2.13 Medicines Management  | 82-83         |
| 6.3 Infrastructure   | 83            |
| 6.3.1 Overview of Healthcare Services  | 83-87         |
| 6.3.2 Mental Health Services   | 88-89         |
| 6.4 Descriptions of other Health Services  | 89-90         |
| 6.4.1 Opportunities for Self Care  | 89-90         |
| 6.5 Primary Care Services  | 90            |
| 6.5.1 Optical  | 90-91         |
| 6.5.2 GP Service   | 91-93         |
| 6.5.3 Pharmacy   | 94-95         |
| 6.5.4 Physical Environment   | 95-96         |
| 6.6 Health Service Activity  | 97-98         |
| <b>7.0 CORPORATE NEEDS ASSESSMENT</b>  | <b>99–127</b> |
| 7.1 Summary Stakeholder Responses  | 99-100        |
| 7.2 What things contribute to health within a prison environment?  | 100           |
| 7.2.1 Lancaster Farms  | 100           |
| 7.2.2 Kirkham  | 101           |
| 7.2.3 Preston  | 102-103       |
| 7.2.4 Garth  | 104           |
| 7.2.5 Wymott   | 104-105       |
| 7.3 Are Healthcare Services within the prison equivalent to those found in the community?  | 105–107       |
| 7.3.1 Lancaster Farms  | 105           |
| 7.3.2 Kirkham  | 105-106       |
| 7.3.3 Preston  | 106           |
| 7.3.4 Garth  | 106-107       |
| 7.3.5 Wymott   | 107           |
| 7.4 What are the most frequent issues that arise in relation to healthcare?  | 107-109       |
| 7.4.1 Lancaster Farms  | 107           |
| 7.4.2 Kirkham  | 108           |
| 7.4.3 Preston  | 108-109       |
| 7.4.4 Garth  | 109           |
| 7.4.5 Wymott   | 109           |
| 7.5 Does the prison 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 whilst in custody and help prisoners adopt healthy behaviours that can be taken back into the community upon release. | 110-112       |

|  |                |
|--|----------------|
| 7.5.1 Lancaster Farms  | 110-111        |
| 7.5.2 Kirkham  | 111            |
| 7.5.3 Preston  | 111-112        |
| 7.5.4 Garth  | 112            |
| 7.5.5 Wymott   | 112            |
| 7.6 How easy is it for prisoners to access a health professional?                                    | 113-114        |
| 7.6.1 Lancaster Farms  | 113            |
| 7.6.2 Kirkham  | 113            |
| 7.6.3 Preston  | 113-114        |
| 7.6.4 Garth  | 114            |
| 7.6.5 Wymott   | 114            |
| 7.7 How can prison staff contribute to the wellbeing of prisoners?                                   | 114-116        |
| 7.7.1 Lancaster Farms  | 114-115        |
| 7.7.2 Kirkham  | 115            |
| 7.7.3 Preston  | 116            |
| 7.7.4 Garth  | 116            |
| 7.7.5 Wymott   | 116            |
| 7.8 What type of support and services in the prison are required to meet the needs of the prisoners? | 117-119        |
| 7.8.1 Lancaster Farms  | 117            |
| 7.8.2 Kirkham  | 117            |
| 7.8.3 Preston  | 118            |
| 7.8.4 Garth  | 118-119        |
| 7.8.5 Wymott   | 119            |
| 7.9 Prisoner Questionnaire Responses   | 119-127        |
| 7.9.1 Garth  | 119-123        |
| 7.9.2 Wymott   | 123-127        |
| <b>8.0 DISCUSSIONS</b>   | <b>128-131</b> |
| <b>10.0 RECOMMENDATIONS</b>  | <b>132-139</b> |
| <b>Appendix 1 – Population and Capacity (Ministry of Justice)</b>                                    | <b>140</b>     |
| <b>Appendix 2 – List of Abbreviations</b>  | <b>141-143</b> |

# 1. INTRODUCTION

The majority of the prison population are from lower socio-economic groups and tend to suffer poorer health than the general population, with some marked inequalities. Primary Care Trusts are responsible, through the commissioning of healthcare services for those prisons within their geographical boundaries, of improving the health of this disadvantaged group and ensuring equivalence of health services to those available in the community. Until March 2011, North Lancashire PCT and Central Lancashire PCT had six prisons within their boundaries but this has been reduced to five with the closure of HMP Lancaster Castle.

Prison Partnership Boards are required to ensure that a baseline prisons health needs assessment is undertaken using a structured assessment tool with an annual review and amendment by the DPH or appropriate deputy. This is assessed under the Prison Performance Indicators with the production of appropriate supporting evidence i.e.

## Green Indicator

A baseline health needs assessment has been completed using a structured assessment tool. There is evidence that the health needs assessment has been reviewed and amended within the last 12 months by the Director of Public Health of the local PCT (or appropriate deputy), as appropriate to the establishment. It **also** contains agreed annual health priorities, which are published in the local prison health delivery plan and signed off by the prison governor and the Chief Executive of the local PCT.

Therefore this health needs assessment has been requested by the Prison Partnership Boards for both North and Central Lancashire to update the current baseline and annually reviewed HNA and will focus on identifying the health needs of prisoners within the five establishments. It will build on the previous Health Needs Assessments and facilitate future commissioning decisions.

The aim of this HNA is to:

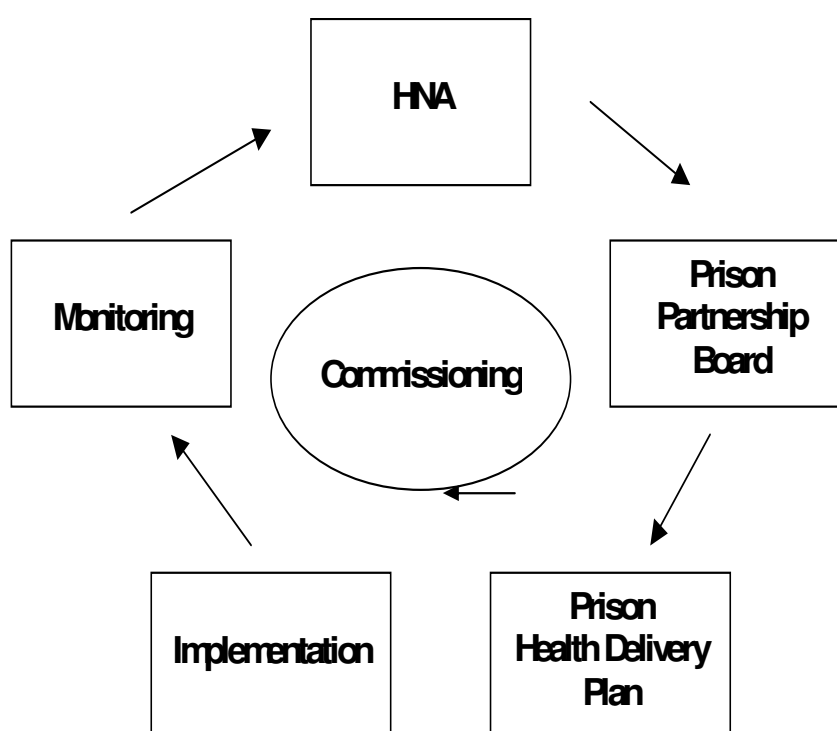
- Provide information in order to plan, negotiate and change services for the better and to improve health in other ways.
- To build a picture of current services – the baseline
- To identify unmet health needs among prisoners.

## 2. BACKGROUND TO HEALTH NEEDS ASSESSMENT

### 2.1 WHAT IS A HNA?

A HNA is a tool to systematically review the health issues facing a population, leading to agreed priorities that aim to improve health and reduce health inequalities. A HNA is not a one-off, stand alone exercise. In order to influence the delivery of healthcare, it needs to be incorporated into the decision-making cycle for prison healthcare, with commissioning central to the process.

**Figure 1**      **Diagram of the Prison HNA Cycle**



For this study, the definition of healthcare is not restricted solely to treatment: it encompasses a range of interventions including prevention, diagnosis, continuing care and rehabilitation.



## 2.2 NEEDS EXPLAINED

Need in healthcare is defined as an *individual's ability to benefit from healthcare*. This means that there is only a meaningful need for healthcare when an individual has a health problem (or runs the risk of developing a health problem) **and** there is an *effective intervention* for that problem.

Needs can be *met* or *unmet*. Met needs are those in which improvements in health are required – but effective interventions are already in place to meet those needs. Unmet needs on the other hand, are those needs where effective interventions are not yet in place. A key aim of HNAs is to identify these unmet needs.

A distinction also needs to be made between *need* and *demand*. Demand is what patients or professionals ask for, and is influenced by many factors (such as the supply of a service and beliefs about its benefits). A common mistake is to equate demand with need.

## 2.3 AIM OF HNA

The aim of this HNA is to:

- Provide information in order to plan, negotiate and change services for the better and to improve health in other ways.
- To build a picture of current services – the baseline.
- To identify unmet health needs among prisoners.

## 2.4 METHODOLOGY

This HNA uses the University of Birmingham “Toolkit for health care needs assessment in prisons”<sup>1</sup>

It uses a number of approaches, which are outlined below.

1. **Epidemiological** – profile of the prison populations and data relating to the prevalence of physical health, mental health, communicable diseases, drug abuse and dental health problems.

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<sup>1</sup> Marshall T. Simpson S. Stevens A. 2000 Toolkit for health care needs assessment in prisons. Department of Public Health and Epidemiology University Birmingham

2. **Comparative** – describing and comparing the services provided in each of the prisons with each other and other providers, e.g. the community and other prisons.
3. **Corporate** – obtaining stakeholder views on what is needed, including the views of prisoners, prison and healthcare staff.

Further details of how the data/information has been obtained are described throughout the Results section.

## 3. LANCASHIRE PRISON ESTATE

The five prisons within Lancashire are all male establishments but of a different category. These are:

- HMP Preston
- HMP Garth
- HMP Wymott
- HMP Kirkham
- HMYOI Lancaster Farms

### 3.1 HMP PRESTON

The HMCIP Inspection Report 2009 reported that *“HMP Preston is an overcrowded, largely Victorian, inner city local prison with a transient population of needy and sometimes challenging prisoners. Yet despite these constraints and demands, this announced full inspection found the prison to be performing reasonably well against all our tests of a healthy prison.”*<sup>2</sup>

Preston is substantially an old Victorian radial prison which is on a site that has been used as a prison or military establishment on and off since 1790. It currently opened as a civilian prison in 1948 and became a local category B prison in 1990 receiving all adult male prisoners from Crown Courts and Magistrates Courts serving Lancashire and Cumbria. It provides accommodation in cells in four main wings, and this breaks down into:

#### Description of residential units

**A wing (3, 4 and 5s)** Mixed convicted and remand prisoners

A2 landing Reintegration unit. Mixed convicted and remand prisoners

A1 landing Segregation unit

**B wing** Mixed convicted and remand prisoners

C3 and 4s Mixed convicted and remand prisoners

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<sup>2</sup> Report on an announced inspection of **HMP Preston** 10-14 August 2009 by HM Chief Inspector of Prisons accessed 18/04/11 at <http://www.justice.gov.uk/inspectorates/hmi-prisons/kirkham.htm>

C2 landing Vulnerable prisoner unit. Mixed convicted and remand prisoners.

C1 landing Drug dependency unit. Mixed convicted and remand prisoners

**D wing** First night centre and induction. Mixed convicted and remand prisoners

**F wing** Convicted risk-assessed workers.

**G wing** Convicted risk-assessed workers.

**Hospital** General medical and mental health, including area resource. Mixed convicted and remand prisoners.

### 3.2 HMP GARTH

The HMCIP Inspection Report 2009 outlined the most recent description of HMP Garth and introduced the up to date position with the types of prisoner and nature of offences. They report that:

*'HMP Garth is a category B training prison, holding men who have committed serious and violent offences and are serving long or indeterminate sentences. These are not easy prisons to run safely and well – holding a population that is similar to that found in high security prisons, but without the same level of resources. In addition, Garth had recently had to cope with the sudden arrival of a large number of men, often relatively young, serving indeterminate sentences for public protection (IPP) and had taken on the role of a first stage lifer prison for the North West. This had resulted in a six-fold increase in the number of indeterminate-sentenced prisoners since the last inspection. It is therefore to the great credit of managers and staff that this inspection found Garth to be one of the most effective and well-run adult prisons we have inspected'.<sup>3</sup>*

Garth is a category B training prison which was opened in October 1988 with a new residential unit (housing 120) opened in 1997, and a further 180 places were provided in August 2007. It receives prisoners who are serving a sentence of four or more years and prisoners who are in the second stage of their life sentence.

#### Description of residential units

A, B C and D wings were the oldest accommodation and built to the same design. Each had three landings. Landings 1 and 2 each had three spurs and landing 3 had

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<sup>3</sup> Report on an announced inspection of **HMP Garth** 30 March – 3 April 2009 by HM Chief Inspector of Prisons accessed 18/04/11 at <http://www.justice.gov.uk/inspectorates/hmi-prisons/garth.htm>

two spurs. Each of these wings could accommodate up to 133 prisoners, but on average 120 spaces were occupied. These older wings had five single cells certified as suitable to accommodate two prisoners. D1 was the evaluation and reallocation unit.

E wing provided accommodation on two landings with spaces for a total of 118 prisoners: 44 on the therapeutic community and 74 on the voluntary drug testing unit. The wing was full and all prisoners had single cells. F wing provided 89 places. F3 was used as the first night and induction unit. G wing could accommodate up to 92 prisoners. Ten single cells on F wing and five on G wing had been certified as suitable for two prisoners.

### 3.3 HMP WYMOTT

The HMCIP Inspection Report 2008 reported that: *“Overall, this is a very positive report on a prison that has managed to progress despite a considerably increased, and very varied, population. Unlike many similar prisons, Wymott was in fact as well as in name a training prison, providing both sufficient quality and quantity of activity. In other areas, and particularly in resettlement, there were issues that need to be tackled if the prison is to continue to improve and to provide a safe and effective environment for the thousand prisoners held there.”*<sup>4</sup>

Wymott is a, male category C training prison which has facilities for vulnerable prisoners. It opened in 1979 as short term category C prison. The prison accepts prisoners with any length sentence. The following wings provide the accommodation for prisoners:

#### **Wing name Type of prisoner Numbers held**

A Vulnerable Prisoners 191

B Vulnerable Prisoners 191

C & D Recovery Wings Cat C 228

E Cat C General 116

F Induction Wing 71

G Vulnerable Prisoners 94

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<sup>4</sup> Report on an announced inspection of **HMP Wymott** 20–24 October 2008 by HM Chief Inspector of Prisons accessed 18/04/11 at [http://www.justice.gov.uk/inspectionreports/hmi-prisons/docs/Garth\\_2009\\_rps.pdf](http://www.justice.gov.uk/inspectionreports/hmi-prisons/docs/Garth_2009_rps.pdf)

H Cat C General 109

I Elderly & Disabled Community 66

J Vulnerable Prisoners 40

K Therapeutic Community 70

**Totals All 1176**

### **3.4 HMYOI LANCASTER FARMS**

The HMCIP Inspection Report 2011 stated that: *“Lancaster Farms has made significant progress since our last visit. It is now a safer place, although the continuing levels of violence mean that there is no scope for complacency. It is now also a decent place, with a more engaged staff and some improved relationships. These are important changes which, together with a step change improvement in the quality of learning and skills, mean that the establishment is in a sound position to re-role to a training function. There will be major challenges ahead, not least ensuring adequate health care and resettlement services to meet future needs but, overall, Lancaster Farms is to be congratulated on how far it has already come.”*<sup>5</sup>

The purpose built prison opened in March 1993 as a Remand Centre/Young Offender Institution with a new residential unit added in 1996. In 2001 two units were re-designated as Juvenile units (under 18's) until 2008/09 when the prison was once again re-roled to become the sole dedicated Young offender Institution for the North West. In August 2011 the prison will re-role to become a Young Offenders' training prison.

The young adults (18 -21) are convicted prisoners. There are a small population of IPP prisoners

#### **Description of residential units**

It provides mainly single cell accommodation but some doubles in four residential units – Coniston, Derwent, Windermere and Buttermere – each divided into two units with 60 cells.

Coniston 1 is the induction unit.

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<sup>5</sup> Report on an unannounced full follow up inspection of **HMYOI Lancaster Farms 1-10 June 2011** by HM Chief Inspector of Prisons

### 3.5 HMP KIRKHAM

The HMCIP Inspection Report 2009 said that: *“Kirkham is an impressive open prison. It manages its risks well, focusing on safety, setting appropriate boundaries and confronting poor behaviour. Prisoners respond well, feel safe and the level of absconding has fallen significantly. Staff-prisoner relationships are good, supported by some of the best personal officer and prisoner-led advice work that we have come across. The prison is also very purposeful and active, with a wholly appropriate focus on resettlement. The governor and staff deserve considerable praise for what has been achieved.”*<sup>6</sup>

Kirkham is a category D training prison occupying the site of a former RAF technical training centre. The facility was taken over by the Home Office in the early 1960's and has been in use as a prison since 1962. With few exceptions the infrastructure and services, together with the buildings, are of World War II vintage, though prisoner accommodation is relatively new. The prison accepts ALL suitable prisoners who fit Kirkham's criteria (all are cat D prisoners who can reasonably be trusted to serve their sentence in open conditions). No medical condition which requires 24 hour care.

#### **Description of residential units**

Accommodation comprises of 24 dormitories of varying size. Every dormitory has its own telephone. 572 single room accommodation with own key, 9 rooms only are double occupancy i.e. 2 listeners suites and 7 double rooms in the ambulant dormitory individual own key. All rooms have Freeview TV access 3 dormitories have personal en-suite facilities inc showers. All prisoners have access to in-room TV. Limited disabled facilities with wheelchair access. There is also a 39-bed Next Steps Centre, which has been developed to promote independent living and reintegration into the community.

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<sup>6</sup> Report on an announced inspection of **HMP Kirkham** 30 November – 4 December 2009 by HM Chief Inspector of Prisons accessed on 18/04/11 at <http://www.justice.gov.uk/inspectors/hmi-prisons/kirkham.htm>

**Table 1 Overview of Each Prison**

|  | Kirkham   | Lancaster Farms | Preston   | Garth     | Wymott    |
|--|-----------|-----------------|-----------|-----------|-----------|
| Year Opened as Prison (1)  | 1962      | 1993            | 1990      | 1988      | 1979      |
| Sex of Prisoners (1)   | Male      | Male            | Male      | Male      | Male      |
| Age of prisoners (1)   | 21+ years | 18 to 21 years  | 18+ years | 21+ years | 21+ years |
| Category (1) *   | D         | YOI             | B         | B         | C         |
| Certified normal accommodation   | 592       | 530             | 449       | 812       | 1081      |
| Operational Capacity (1)****   | 592       | 530             | 842       | 847       | 1176      |
| No. of New Prisoners Received in past 12 months (2)  | 926       | 2125            | 3690      | 421       | 1001      |
| Approximate turnover of prison population each year<br>(calculated by no. of new prisoners in a year/operational capacity) | 1.6       | 4.0             | 4.38      | 0.5       | 0.9       |
| % Prisoners sentenced / on remand (3)  | 100/0     | 100/0**         | 55/45     | 100/00    | 100/0     |

\* Definition of prison categories can be found in Appendix 1

\*\* Lancaster Farms will cease to have remand prisoners from August 25<sup>th</sup> 2011 and will become a training prison

\*\*\* Preston changed to take both young offenders and adult males on remand from 25<sup>th</sup> July 2011

\*\*\*\*Kirkham increased its capacity to 630 from September 2011 and all tables for expected prevalence are based on this new number.

Sources of Data:

- (1) HMP Service Website <http://www.hmprisonservice.gov.uk>
- (2) Data obtained from Prison Healthcare – reception/transfers screening between 1<sup>st</sup> April 2010 - 31<sup>st</sup> March 2011
- (3) Data obtained from Prison Service – one day snapshot on HMYOILF 1/10/10



Key points to note from Table 1 are the differences in turnover of prisoners between prisons. In terms of health care provision each new arrival generates a workload for the health care system in terms of reception screening and any initial management of existing health conditions. Although poor mental health is significantly higher in the prison population than the general population, there is greater prevalence of poor mental health amongst remand prisoners.<sup>7</sup> It is expected that the turnover in the Farms will reduce substantially when it becomes a training prison in August 2011.

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<sup>7</sup> Marshall T, Simpson S. Stevens A. Chapter 11: Health Care in Prisoners in Stevens A. Raftery J, Simpson S. Health Care Needs Assessment – The Epidemiological Based Needs Assessment Reviews, Radcliff Publishing 2007.

## 4. PRISON POPULATION PROFILE

In general the prison population has three key features, it is largely male, young and with a high turnover. Only 1 in 20 prisoners are women. A snapshot of people in prison by the Prison Reform Trust<sup>8</sup> found that:

- ***The average age of those sentenced to custody in 2006 was 27.*** A quarter was aged 21 or under.
- ***The number of sentenced prisoners aged 60 and over rose by 142% between 1998 and 2008.***
- ***On 30 June 2009 just under 27% of the prison population, 22,292 prisoners, was from a minority ethnic group.*** This is the same proportion as in the previous year (2008), but is an increase on 2005 (25%). This also compares to one in 11 of the general population.
- ***At the end of March 2010 there were 11,367 foreign national prisoners (defined as non-UK passport holders), 13% of the overall prison population.***
- ***According to the Ministry of Defence, around 3% of the prison population in England and Wales are former armed forces personnel.*** This equated to over 2,500 people on 6 April 2010.
- ***20–30% of all offenders have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system.***
- ***23% of young offenders have learning difficulties (IQ below 70) and 36% borderline learning difficulties (IQ 70–80%).***
- ***In HM Inspectorate of Prison surveys, 15% of people in prison reported a disability.***

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<sup>8</sup>Prison Reform Trust Bromley Briefings Prison Factfile *December 2010* Accessed 18/04/11 at: <http://www.prisonreformtrust.org.uk/uploads/documents/FactFileJuly2010.pdf>

## 4.1 AGE PROFILE

Table 2 Age profile of prisoners in Lancashire

|       | Kirkham * |       | Lancaster Farms ** | Preston *** |       | Garth *** |       | Wymott *** |       |
|-------|-----------|-------|--------------------|-------------|-------|-----------|-------|------------|-------|
| 18-21 | 0         | 0     | 530                | 48          | 5%    | 0         | 0     | 35         | 3%    |
| 22-30 | 182       | 30.8% | 0                  | 380         | 40%   | 298       | 35.4% | 382        | 32.4% |
| 31-40 | 208       | 35.1% | 0                  | 284         | 29.6% | 287       | 34.1% | 316        | 26.8% |
| 41-55 | 171       | 28.9% | 0                  | 221         | 23%   | 204       | 24.2% | 288        | 24.4% |
| 55-78 | 31        | 5.2%  | 0                  | 26          | 2.7%  | 54        | 6.4%  | 153        | 13%   |
| 78+   | 0         | 0     | 0                  | 1           | 0.1%  | 0         | 0     | 7          | 0.6%  |
| Total | 592       |       | 530                | 960         |       | 843       |       | 1181       |       |

Data source:

\* Age of prisoners as of March 2011 snapshot.

\*\* one day snapshot on HMYOILF 1/10/10

\*\*\* Data from Prison database. Wymott Prison does not take prisoners who are aged 21 and below. However a number of prisoners are aged 21 and therefore have been categorised in the 18-21 category.

### Lancaster Farms YOI

As a Young offender Institution Lancaster Farms is resident to the 18 to 21 year old age group only. Between Jan 1<sup>st</sup> 2010 and 31<sup>st</sup> Dec 2010 11.8% were aged 18, 31% were aged 19, 44% were aged 20 and 13.4% were aged 21. Preston has also started taking young offenders on remand who made up 5% of their population at the time of data collection and 3% of the prisoners in Wymott are aged 21.

**Young offenders have much higher levels of health need than the general population of adolescents and they tend to utilise services in times of crisis rather than using them in a primary or preventative way.<sup>9</sup>**

<sup>9</sup> MacDonald W. 2006 The Health needs of Young offenders The National Primary care research and development centre University of Manchester

## Adult prisons

In Kirkham, Garth and Wymott prisoners are aged 21 plus. Preston now takes from 18+. Prisoners over the age of 55 are considered elderly prisoners. On 31 March 2010 there were 8,120 prisoners aged over 50 in England and Wales making up about 2.9% of the prison population. (Prison Reform Trust, 2010).<sup>10</sup>

Wymott, Garth and Kirkham all have a higher percentage of older prisoners than the England and Wales average. Wymott has the largest percentage of older prisoners with 13% of the prison population being over 55 and under 78 but has a 0.6% population over the age of 78. Both Garth (6.4%) and Kirkham (5.2%) report a growing number of prisoners within this age group and have an older population percentage that is twice that of Preston (2.7%).

**Prisoners aged 55 years and older present with higher rates of many disorders than do other prisoners e.g. 80% have a long standing chronic illness or disability, 35% suffer from cardiovascular disease and more than 20% suffer from respiratory disease. Also other conditions such as chronic alcohol misuse, smoking and chronic disease including arthritis, hypertension, sexually transmitted infections, ulcers, genitor- urinary problems, are the main reported health issues amongst older prisoners.<sup>11</sup> More than half of all elderly prisoners suffer from a mental disorder. The most common disorder is depression which often emerges as a result of imprisonment.<sup>12</sup>**

**In addition, older prisoners may require specific services for age-related disability and disease (e.g. arthritis, hearing impairment, dentures, and visual problems) as well as physical concessions (e.g. lower bunks, ground floor cells)<sup>13</sup>**

## 4.2 ETHNICITY

On 30 June 2010 just under 26% of the prison population, 21,878 prisoners, was from a minority ethnic group. This is slightly less than in 2009, but represents an

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<sup>10</sup> Prison Reform Trust, information from Offender Policy and Rights Unit, 1 July 2010  
Prison Health Research Network :The Healthcare Challenges of Older People in Prisons – a briefing paper.  
Docherty, JL. <http://www.ohrn.nhs.uk/resource/Research/OlderPrisonersReview.pdf>

<sup>11</sup> Fazel, S & Baillargeon, J (2011). The health of prisoners. The Lancet, Volume 377, Issue 9769, Pages 956 – 965

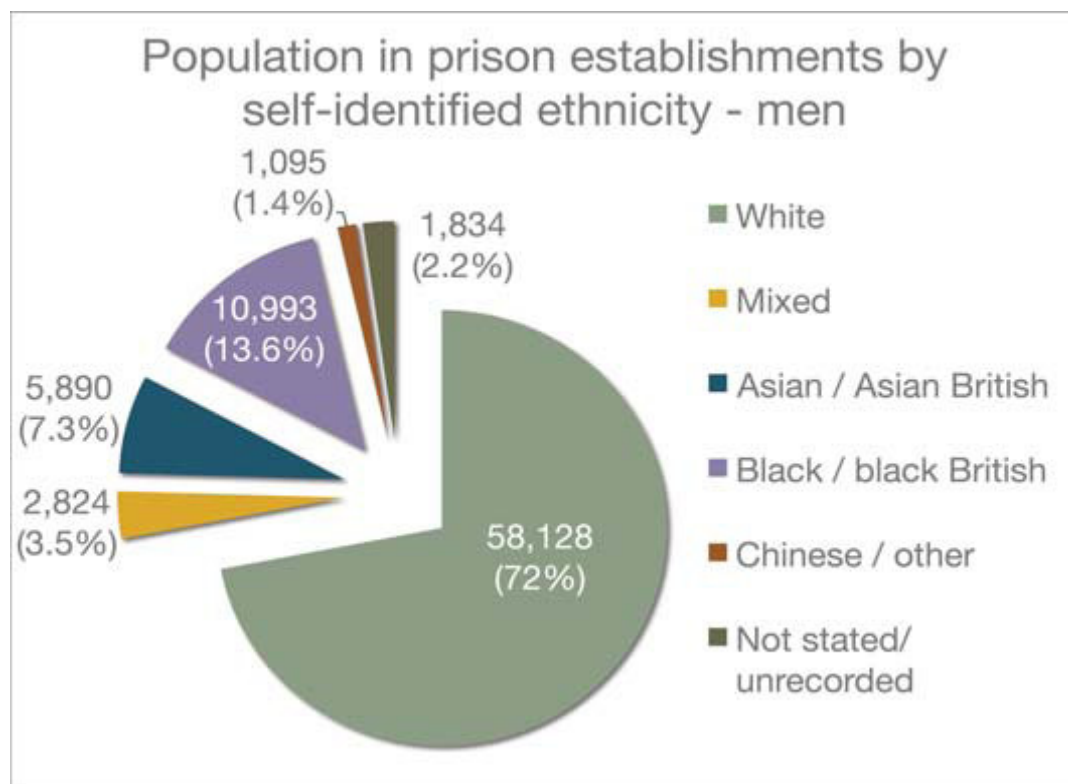
<sup>12</sup> HM Chief Inspector of Prisons for England and Wales (2008) Annual Report 2006-07, London: HM Inspectorate of Prisons

<sup>13</sup> Howse K. 2003. Growing Old in Prison: A Scoping Study on Older Prisoners. London: Prison Reform Trust

increase on that recorded for 2005 (25%) and this compares to one in 10 of the general population<sup>14</sup>

The following table shows the self identified ethnicity of men in prison in England.

**Figure 2 Self identified ethnicity of men in prison**



Source: 345 Table A1.17, Ministry of Justice (2011) Offender Management Caseload Statistics 2010, London: Ministry of Justice in Bromley Briefings Fact file June 2011.

The majority of prisoners within the Lancashire prisons define their ethnic origin as White British although in Kirkham the majority of prisoners declined to provide their ethnic origin.

Table 3 shows the differences in ethnicity between the prison populations. Compared to the population of England where 87.5% of the population is white (mainly white British), ethnic minorities are over-represented in each of the prisons.

**From a health perspective, ethnic minority groups have their own specific health issues, for example, in the Afro-Caribbean population, sickle cell anaemia and mental health problems are major issues. Ethnicity may also affect an individual's understanding of verbal or written English, particularly for foreign nationals.**

<sup>14</sup> Bromley Briefings Prison Factfile June 2011 accessed at: <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Fact%20File%20June%202011%20web.pdf>

**Table 3 Ethnicity of prisoners in Lancashire**

|                             | Kirkham<br>* | Lancaster<br>Farms ** |      | Preston |      | Garth   |      | Wymott  |      | England<br>*** |
|-----------------------------|--------------|-----------------------|------|---------|------|---------|------|---------|------|----------------|
| Asian Indian                | 8            | 10                    |      | 33      | 3.4% | 13      |      | 3       |      | 2.7%           |
| Asian Pakistani             | 31           | 55                    | 2.6% | 9       |      | 29      | 3.4% | 11      |      | 1.9%           |
| Asian Bangladeshi           | 0            | 17                    |      | 1       |      | 3       |      | 0       |      | 0.7%           |
| Asian Other                 | 11           | 15                    |      | 1       |      | 13      |      | 3       |      | 0.7%           |
| Black Caribbean             | 17           | 36                    | 1.7% | 4       |      | 41      | 4.9% | 3       |      | 1.2%           |
| Black African               | 5            | 13                    |      | 4       |      | 9       |      | 2       |      | 1.5%           |
| Black Other                 | 12           | 8                     |      | 13      | 1.4% | 18      | 2.1% | 1       |      | 0.2%           |
| Mixed Caribbean             | 10           | 36                    | 1.7% | 1       |      | 14      | 1.7% | 2       |      | 0.6%           |
| Mixed African               | 0            | 7                     |      | 2       |      | 2       |      | 0       |      | 0.2%           |
| Mixed Asian                 | 3            | 4                     |      | 0       |      | 2       |      | 16      | 3.9% | 0.6%           |
| Mixed Other                 | 0            | 12                    |      | 87      | 9.1% | 7       |      | 0       |      | 0.5%           |
| White British               | 8            | 1797                  | 85%  | 647     | 67%  | 64<br>1 | 76%  | 35<br>8 | 87%  | 82.8%          |
| White Irish                 | 9            | 3                     |      | 1       |      | 9       |      | 10      |      | 1.1%           |
| White Irish traveller/gypsy | 0            | 0                     |      | 4       |      | 0       |      | 1       |      |                |
| White Other                 | 0            | 21                    |      | 9       |      | 25      |      | 2       |      | 3.6%           |
| Not specified/refusal       | 478          | 91                    |      | 144     |      | 17      |      | 0       |      |                |

**Data source.**

\* Age of prisoners as of March 2011 snapshot.

\*\* one day snapshot on HMYOILF 1/10/10

\*\*\* **England** data source ONS: Estimated Population by Ethnic Group

Requires data source for CL prisons

**Table 4 Foreign National Prisoners**

|                          | Kirkham * | Lancaster Farms ** | Preston | Garth | Wymott |
|--------------------------|-----------|--------------------|---------|-------|--------|
| Number foreign nationals | 3         | 14                 | 29      | 61    | 51     |

**Data source: Prison Custody Check – August 2011 snapshot**

Table 4 shows that there a small number of foreign nationals held at each of the prisons at any one time. Further examination of the nationalities of the foreign nationals held at each of the prisons shows a diverse range in the countries of origin, including those from Eastern Europe, Africa, Asia and the Middle East.

**In addition to any language barriers, foreign national prisoners may also suffer disadvantage from social and cultural isolation within the prison system, unfamiliarity of the range of healthcare services available, mental health problems arising from previous experiences in a foreign country and isolation from friends and family due to a geographic divide.**

### **4.3 HOME**

Table 5 shows the home area of prisoners, which can be used to indicate where prisoners may go once released. The majority of prisoners come from the Northwest, whilst over half of the prisoners in HMP Garth are likely to be from outside the Northwest. The majority of prisoners within HMP Preston were from Lancashire. Data relating to how many of the prisoners remain within Lancashire's geographical area was not available.

**This information is important in helping to ensure that the Prison Partnership Board consider the need for liaison with external agencies across the North West and the work around the wider offender health pathways to continue the support to prisoners on release.**

**The distance from home to prison can impact on the ability of families and friends to visit and subsequently impact on the prisoner's mental well being.**

**Table 5 Home address of prisoners**

|                      | Kirkham*   |               | Lancaster Farms** |              | Preston    |              | Garth      |              | Wymott     |              |
|----------------------|------------|---------------|-------------------|--------------|------------|--------------|------------|--------------|------------|--------------|
| Greater Manchester   | 147        | 25%           | 976               | 46%          | 34         | 4.6%         | 76         | 11.3%        | 194        | 21.2%        |
| Lancashire           | 116        | 19.6%         | 508               | 24%          | 598        | 80.5%        | 87         | 13%          | 346        | 37.8%        |
| Merseyside           | 163        | 27.5%         | 371               | 17.5%        | 21         | 17.5%        | 86         | 12.8%        | 108        | 11.8%        |
| Cheshire             | 45         | 7.6%          | 42                | 2%           | 4          | 2.8%         | 34         | 5.1%         | 49         | 5.3%         |
| Cumbria              | 10         | 1.7%          | 112               | 5.3%         | 36         | 0.5%         | 7          | 1%           | 18         | 2.0%         |
| <b>Total N. West</b> | <b>481</b> | <b>81.25%</b> | <b>2009</b>       | <b>94.7%</b> | <b>693</b> | <b>96.0%</b> | <b>290</b> | <b>43.1%</b> | <b>715</b> | <b>78.1%</b> |
| Yorkshire            | 23         | 3.9%          | 39                | 1.8%         | 14         | 1.9%         | 64         | 9.5%         | 37         | 4.0%         |
| Wales                | 16         | 2.7%          | 7                 | 0.3%         | 3          | 0.4%         | 28         | 4.2%         | 34         | 3.7%         |
| North East           | 18         | 3%            | 23                | 1.1%         | 4          | 0.5%         | 68         | 10.1%        | 23         | 2.5%         |
| Scotland             | 6          | 1%            | 3                 | 0.1%         | 4          | 0.5%         | 5          | 0.7%         | 4          | 0.4%         |
| Other                | 48         | 8%            | 41                | 1.9%         | 4          | 0.5%         | 218        | 32.4%        | 103        | 11.2%        |
| <b>Total</b>         | <b>592</b> |               | <b>2122</b>       |              | <b>722</b> |              | <b>673</b> |              | <b>916</b> |              |

**NB: % may not add up to 100 due to rounding.**

\* Home origin of prisoners as of October 2010 snapshot.

\*\* Home origin of all prisoners through the prison between Jan 1<sup>st</sup> 2010 and 31<sup>st</sup> Dec 2010

## 4.4 PRISONER STATUS AND LENGTH OF STAY

Table 6, 7 and 8 show the status of prisoners within the prisons and their length of sentence and stay.

Prisons with a large number of remand and short sentenced prisoners tend to have a larger turnover which raises issues for health care staff with regard to reception screening, continuity of treatment and managing transfer/discharge. Prisoner status also has an effect on some health care conditions e.g. there is greater prevalence of poor mental health amongst remand prisoners.<sup>15</sup>

In addition, those prisoners with longer sentences who grow older in prison may require specific services for age-related disability and disease (e.g. arthritis, hearing impairment, dentures, and visual problems) as well as physical concessions (e.g. lower bunks, ground floor cells)<sup>16</sup>

<sup>15</sup> Marshall T, Simpson S, Stevens A. Chapter 11: Health Care in Prisoners in Stevens A, Raftery J, Simpson S. Health Care Needs Assessment – The Epidemiological Based Needs Assessment Reviews, Radcliff Publishing 2007.

<sup>16</sup> Howse K. 2003. Growing Old in Prison: A Scoping Study on Older Prisoners. London: Prison Reform Trust



**Table 6: Offender status**

| Status                | Kirkham * |       | Lancaster Farms ** |       | Garth |      |
|-----------------------|-----------|-------|--------------------|-------|-------|------|
| Remand                | 0         | 0     | 31                 | 6%    | 0     | 0    |
| Convicted/unsentenced | 0         | 0     | 34                 | 6.6%  | 0     | 0    |
| Sentenced             | 627       | 99.5% | 401                | 77.7% | 847   | 100% |
| Recall                | 3         | 0.5%  | 42                 | 8%    | 0     | 0    |
| Other                 | 0         | 0     | 8                  | 1.6%  | 0     | 0    |
| Total                 | 630       |       | 516                |       | 847   |      |

\* Snapshot 2/11/11

\*\* Snapshot 21/01/11

**Table 7: Length sentence**

| Sentence                            | Kirkham * |        | Lancaster Farms ** |       | Garth |       |
|-------------------------------------|-----------|--------|--------------------|-------|-------|-------|
| Less than 6 months                  | 3         | 0.47%  | 70                 | 13.6% | 0     | 0     |
| 6 months to less than 1 year        | 2         | 0.31%  | 97                 | 18.8% | 0     | 0     |
| 1 year to less than 2               | 13        | 2.06%  | 69                 | 13.4% | 0     | 0     |
| 2 years to less than 3              | 22        | 3.49%  | 37                 | 7.2%  | 5     | 0.6%  |
| 3 years to less than 4              | 43        | 6.82%  | 87                 | 16.9% | 10    | 1.2%  |
| 4 years to less than 10             | 301       | 47.7%  | 52                 | 10.1% | 116   | 13.8% |
| 10 years or more and less than life | 65        | 10.31% | 2                  | 0.4%  | 204   | 24.2% |
| Lifer                               | 181       | 28.73% | 27                 | 5.2%  | 507   | 60%   |
| No sentence                         | 0         | 0      | 75                 | 14.5% | 0     | 0     |
| Total                               | 630       |        | 516                |       | 842   |       |

\* Snapshot 2/11/11

\*\* Snapshot 21/01/11

**Table 8: Length of stay**

| Stay              | Kirkham *  |   | Lancaster Farms ** |            | Garth      |   |
|-------------------|------------|---|--------------------|------------|------------|---|
|                   | S          | U | S                  | U          | S          | U |
| Less than 1 month | 94         |   | 103                | 31         | 44         |   |
| 1 month-3 months  | 126        |   | 139                | 42         | 85         |   |
| 3 months -6       | 139        |   | 59                 | 32         | 92         |   |
| 6 months -1 year  | 174        |   | 52                 | 7          | 165        |   |
| 1 year -2 years   | 116        |   | 43                 | 2          | 207        |   |
| 2 years -4        | 15         |   | 5                  | 0          | 198        |   |
| Other             | 6          |   | 0                  | 1          | 55         |   |
| <b>Total</b>      | <b>630</b> |   | <b>401</b>         | <b>115</b> | <b>846</b> |   |

S = sentenced prisoners

U=unsentenced prisoners

\* Snapshot 2/11/11

\*\* Snapshot 21/01/11

## 4.5 SOCIAL CHARACTERISTICS OF SENTENCED PRISONERS

Table 9. Social characteristics of prisoners in comparison to the general population

| Characteristic   | General population     | Prison population                                 |
|--|------------------------|---|
| Ran away from home as a child                                    | 11%                    | 47% of male and 50% of female sentenced prisoners |
| Taken into care as a child                                       | 2%                     | 27%   |
| Regularly truanted from school                                   | 3%                     | 30%   |
| Excluded from school   | 2%                     | 49% of male and 33% of female sentenced prisoners |
| No qualifications  | 15%                    | 52% of men and 71% of women                       |
| Numeracy at or below Level 1<br>(level expected of 11-year-olds) | 23%                    | 65%   |
| Reading ability at or below Level 1                              | 21-23%                 | 48%   |
| Unemployed before imprisonment                                   | 5%                     | 67%   |
| Homeless   | 0.9%                   | 32%   |
| Suffer from two or more mental<br>Disorders                      | 5% men<br>2% women     | 72% of male and 70% of female sentenced prisoners |
| Psychotic disorder   | 0.5% men<br>0.6% women | 7% of male and 14% of female sentenced prisoners  |
| Drug use in the previous year                                    | 13% men<br>8% women    | 66% of male and 55% of female sentenced prisoners |
| Hazardous drinking   | 38% men<br>15% women   | 63% of male and 39% of female sentenced prisoners |

## 4.6 IMPACT ON IMPRISONMENT ON SIGNIFICANT OTHERS AND FAMILY

Imprisonment also has an effect on partners and families. Research by The Social Exclusion unit<sup>17</sup> found that:

- ***More than two in three of all prisoners are unemployed when they go to jail.*** But research by nacro has found that remand prisoners are less likely than sentenced prisoners to have had a job before prison. The minority of remand prisoners who do have jobs are very likely to lose them whilst in prison.
- ***In 2006, more children were affected by the imprisonment of a parent than by divorce in the family.***
- ***During their time at school 7% of children experience their father's imprisonment.***
- ***Home Office research has found that 66% of women and 59% of men in prison have dependent children under 18.*** Of those women, 34% had children under 5, a further 40% children aged from 5 to 10. Each year it is estimated that more than 17,700 children are separated from their mother by imprisonment.
- ***25% of young men in young offender institutions are, or are shortly to become, fathers.***
- ***65% of boys with a convicted parent, go on to offend.***
- ***55% of men described themselves as living with a partner before imprisonment.***
- ***Prisoners' families, including their children, often experience increased financial, housing, emotional and health problems during a sentence.*** Children of prisoners have about three times the risk of mental health problems and the risk of anti-social/delinquent behaviour compared to their peers.
- ***During their sentence 45% of people lose contact with their families and many separate from their partners.***
- ***Research indicates that having family ties can reduce the likelihood of reoffending by 39%.***
- ***However, many prisoners are still held a long way from their homes.*** On 8 May 2009, 32,126 people in prison were being held over 50 miles away from their normal place of residence.

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<sup>17</sup> Social Exclusion Unit (2002) *Reducing reoffending by ex-prisoners*, London: Social Exclusion Unit

- ***In recent years the number of prison visits has fallen despite an increasing prison population.***
- ***Remand prisoners are more likely than sentenced prisoners to have a history of living in unstable or unsuitable accommodation.*** Research by the National Association for the Care and Resettlement of Offenders (nacro) shows they are five times more likely to have lived in a hostel prior to imprisonment.
- ***Remand prisoners receive no financial help from the Prison Service at the point of release.*** They are also not eligible for practical support with resettlement from the Probation Service, even though they can be held on remand for as long as 12 months.

## 5. EPIDEMIOLOGICAL NEEDS ASSESSMENT

### 5.1 PREVALENCE OF HEALTH CONDITIONS

In this section, disease prevalence in the five prisons has been estimated using baseline data from the book: Health Care Needs Assessment (2006), Chapter 11 - "Health Care in Prisons"<sup>18</sup>. Where more recent national prevalence data has been used, this has been referenced. Where possible, national community prevalence data has also been presented to enable comparisons to be made.

The overall prevalence (%) and expected number of prisoners with a condition has been calculated using age-specific data where possible. This takes into account that certain diseases are more common in certain age groups, i.e. asthma is more prevalent in younger populations (and therefore the Farms is expected to have a higher prevalence of asthma), whereas heart disease is more common in older people (and therefore Wymott, Kirkham and Garth are expected to have a higher prevalence). In addition, local data is presented for the prisons extracted from the System One computer databases where possible. System One has been installed and is being used for health surveillance amongst prisoners in all five prisons in Lancashire. However, despite there being a sophisticated section to record QOF prevalence and benchmark against national rates, there is little evidence that it is being used effectively. Prevalence figures taken from the system show extremely low prevalence rates for conditions that are expected to be high in these prisons such as Mental Health.

***Caution should be applied in interpreting the local data as it is reliant on correct and consistent coding of diseases by healthcare professionals, which may also be incomplete and therefore likely to underestimate prevalence.*** Therefore, the calculated expected data is likely to be more accurate however during

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<sup>18</sup> Marshall T. Simpson S. Stevens A. Chapter 11 Health care in prisons updated version of a chapter in The Health Care Needs Assessment series, funded by the Department of Health/National Institute for Health and Clinical Excellence (NICE), was compiled and managed in the Unit of Public Health, Epidemiology & Biostatistics at the University of Birmingham accessed at: . <http://www.hcna.bham.ac.uk/chapters.shtml>

the process of this HNA the number of prisoners within the prisons has changed so there may be some inconsistencies with expected numbers within the prisons.

|  |
|--|
| <b>Prevalence explained</b><br>Prevalence provides a measure of the population burden of a disease, and therefore assists with service planning. There are two measures of prevalence: <b>point prevalence</b> and <b>period prevalence</b> . Point prevalence is the number of persons with a disease <i>at a single point in time</i> , whereas period prevalence relates to the number of persons with a disease <i>at any time over a specified period</i> . In this section, <b>period prevalence over 12 months</b> has been used as this takes into account the transient nature of the prison populations. |
| <b>QOF Prevalence</b><br>Quality Outcomes Framework (QOF) prevalence is the number of patients on a prisons clinical register which can be used to calculate measures of disease prevalence, expressing the number of patients on each register as a percentage of the number of patients on the practice (prison) list.   |
|  |

## 5.2 PHYSICAL HEALTH

### 5.2.1 Minor illness

Minor illness is used to describe self limiting conditions such as skin diseases, respiratory illness (excluding asthma), infectious diseases, allergies and musculoskeletal conditions that frequently occur in the community and are the most common reasons for GP consultation.<sup>19</sup>

In males aged 16-44 the most common reason for GP consultation in the community are respiratory conditions, injuries, infectious diseases and skin disorders.

Over 60s level of self reporting is generally similar however they are more likely to report with social and disability needs e.g. eyesight, hearing, genito-urinary problems.

<sup>20</sup>

### 5.2.2 Long Term Conditions

A large-scale UK study has reported higher rates of chronic diseases amongst prisoners when compared to the wider community; 46% of their sample of sentenced males had some form of longstanding illness or disability such as heart disease, asthma and diabetes.<sup>21</sup>

#### 5.2.2.1 Epilepsy

Epilepsy is the most common chronic disabling neurological condition in the UK. The age-standardised prevalence of epilepsy in the UK is estimated to be 7.5 per 1000 population.<sup>22</sup>

In male prisoners the prevalence of epilepsy is 1.1%, 0.7%, 0.6%, and 0.8% aged 16-24, 25-34, 35-44, 45-64 years, respectively.<sup>23</sup>

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<sup>19</sup> Marshall T, Simpson S, Stevens A. Chapter 11 Health care in prisons updated version of a chapter in The Health Care Needs Assessment series, funded by the Department of Health/National Institute for Health and Clinical Excellence (NICE), was compiled and managed in the Unit of Public Health, Epidemiology & Biostatistics at the University of Birmingham accessed at: . <http://www.hcna.bham.ac.uk/chapters.shtml>

<sup>20</sup> <http://www.ohrn.nhs.uk/resource/Research/OlderPrisonersReview.pdf>

<sup>21</sup> Bridgwood A, Malbon, G,. 1995. Survey of the physical health of prisoners 1994: a survey of sentenced male prisoners in England and Wales. London: The Stationery Office

<sup>22</sup> Accessed at:

<http://www.nice.org.uk/usingguidance/commissioningguides/epilepsiesinadults/assumptionspopulationbenchmark.jsp>

<sup>23</sup> Marshall T, Simpson S and Stevens A. Health care in prisons: a health care needs assessment. Department of Public Health and epidemiology, University of Birmingham, 1999



Analysis of the data suggests that the prevalence of diagnosed epilepsy in people aged 15 years and older is 1.15%. This estimate is higher than the unadjusted QOF prevalence for England for 2006/2007 for epilepsy of 0.6%.<sup>24</sup>

**Table 10: Expected Number of prisoners with Epilepsy**

| Epilepsy                                       | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|--|----------------|---|-------------------------------|-----------------------------|------------------------------|-------------------------------|
| <b>Operational capacity - Total Population</b> |                |   |                               |                             |                              |                               |
| Age range                                      |                | <b>530</b>                              | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| 16-24  | 1.1            | 6                                       | 0                             | 0                           | 0.4                          | 0.5                           |
| 25-34  | 0.7            | 0                                       | 1.4                           | 2.1                         | 2.7                          | 2.7                           |
| 35-44  | 0.6            | 0                                       | 1.3                           | 1.7                         | 1.9                          | 1.7                           |
| 45 +   | 0.8            | 0                                       | 1.6                           | 2.1                         | 1.3                          | 2                             |
| <b>TOTAL *</b>                                 |                | <b>6</b>                                | <b>4</b>                      | <b>6</b>                    | <b>6</b>                     | <b>7</b>                      |
| <b>Actual</b>                                  |                | <b>5</b>                                | <b>9**</b>                    |                             |                              |                               |

\*Total number is rounded.

\*\* Data for epilepsy is linked to electronic prescribing. Although clinics in place it doesn't pick up the data until linked electronically. Currently there are 9 men with epilepsy however the system only recognises one man who was transferred from another prison with electronic prescribing in place.

**Table 11: Prisons QoF Epilepsy prevalence**

| Epilepsy                                      | Target Range | Garth        | Kirkham  | Lancaster Farms | Preston     | Wymott       |
|---|--------------|--------------|----------|-----------------|-------------|--------------|
| EPILEPSY05 - Epilepsy register                |              | 0.20% (2)    | 1        | 100% 5/5        | 0.20% (2)   | 0.40% (5)    |
| EPILEPSY06 - seizure frequency recorded 15/12 | 40-90%       | 50.00% (1/2) | 100% 1/1 | 20% 1/5         | 0.00% (0/2) | 20.00% (1/5) |
| EPILEPSY07 - Medication review in last 15m    | 40-90%       | 50.00% (1/2) | 100 1/1  | 100% 5/5        | 0.00% (0/2) | 0.00% (0/5)  |
| EPILEPSY08 - Seizure free in last 12m         | 40-70%       | 0.00% (0/2)  | 100% 1/1 | 40% 2/5         | 0.00% (0/2) | 0.00% (0/5)  |

<sup>24</sup> <http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/audits-and-performance/the-quality-and-outcomes-framework/qof-2006/07/qof-2006-07-data-tables>

### 5.2.2.2 Asthma

The national prevalence of asthma is 5.9% (QoF 09/10). In male prisoners the estimated prevalence is around 13%.<sup>25</sup>

**Table 12: Expected Number of prisoners with Asthma**

| Asthma   | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|--|----------------|---|-------------------------------|-----------------------------|------------------------------|-------------------------------|
| <b>Operational capacity - Total Population</b> |                |   |                               |                             |                              |                               |
|  |                | <b>530</b>                              | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| <b>TOTAL</b>                                   | <b>13%</b>     | <b>69</b>                               | <b>82</b>                     | <b>110</b>                  | <b>148</b>                   | <b>104</b>                    |
| <b>Actual</b>                                  |                | <b>21</b>                               | <b>97</b>                     |                             |                              |                               |

Asthma is a potentially life threatening condition and a number of widely accepted guidelines are available on the management of asthma; however there is no set guidance for the management of asthma in a prison setting.

**Table 10: Prisons QoF Asthma prevalence**

| Asthma   | Target Range | Garth         | Kirkham     | Lancaster Farms | Preston      | Wymott        |
|--|--------------|---------------|-------------|-----------------|--------------|---------------|
| ASTHMA01 - Register                              |              | 2.20% (20)    | 38          | 100% (21)       | 0.70% (7)    | 1.80% (22)    |
| ASTHMA03 - Asthma (14 - 19 yrs) & Smoking status | 40-80%       | 0.0% (0/20)   | n/a         | 100%            | 0.00% (0/7)  | 0.00% (0/0)   |
| ASTHMA06 - Review in previous 15 months          | 40-70%       | 10.00% (2/20) | 45.1% 14/31 | 6               | 14.20% (1/7) | 4.50% (1/22)  |
| ASTHMA08 - Diagnosed as having asthma            | 40-80%       | 23.50% (4/17) | 43.3% 13/30 | 75% 14          | 50.00% (3/6) | 44.40% (8/18) |

### 5.2.2.3 COPD

COPD stands for chronic obstructive pulmonary disease. This is a term used for a number of conditions; including chronic bronchitis and emphysema.

The rate of COPD in the population is estimated at between 2% and 4%, representing between 982,000 and 1.96 million people in England.<sup>26</sup> The national QOF prevalence of COPD is 1.6% (QoF 09/10).

<sup>25</sup> Marshall T, Simpson S and Stevens A. Health care in prisons: a health care needs assessment. Department of Public Health and epidemiology, University of Birmingham, 1999

<sup>26</sup> Source: Eastern Region Public Health Observatory, September 2008

**Table 11: Expected Number of prisoners with COPD**

| COPD          | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms        | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|---------------|----------------|--|-------------------------------|-----------------------------|------------------------------|-------------------------------|
|               |                | <b>Operational capacity - Total Population</b> |                               |                             |                              |                               |
|               |                | <b>530</b>                                     | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| <b>TOTAL</b>  | <b>3%</b>      | <b>16</b>                                      | <b>19</b>                     | <b>25</b>                   | <b>36</b>                    | <b>26</b>                     |
| <b>Actual</b> |                | <b>0</b>                                       | <b>6</b>                      |                             |                              |                               |

Prison prevalence is likely to be much higher than national average, as up to 80% of prisoners smoke and COPD is present in 18% of male smokers in the UK. COPD symptoms usually develop in 50+ so age break down of prison population may also have a bearing. Therefore it is expected that higher prevalence would be seen in Wymott, Garth and Kirkham where there are a greater percentage of older prisoners and it is unlikely that the Farms would have any prisoners with COPD.

**Table 12: Prisons QoF COPD prevalence**

| COPD                                    | Target Range | Garth        | Kirkham   | Lancaster Farms | Preston     | Wymott        |
|---|--------------|--------------|-----------|-----------------|-------------|---------------|
| COPD01 - Register                       |              | 1.00% (9)    | 6         | 0               | 0.50% (5)   | 1.50% (19)    |
| COPD08 - Influenza immunisation         | 40-85%       | 0.00% (0/9)  | 66.6% 4/6 | 0               | 0.00% (0/5) | 0.00% (0/18)  |
| COPD10 - FeV1 in the previous 15 months | 40-70%       | 0.00% (0/9)  | 0% 0/5    | 0               | 0.00% (0/5) | 11.10% (2/18) |
| COPD12 - COPD confirmed by spirometry   | 40-80%       | 12.50% (1/8) | 25% 1/4 * | 0               | 0.00% (0/5) | 25.00% (4/16) |
| COPD13 - Review + MRC                   | 50-90%       | 0.00% (0/9)  | 16.6% 1/6 | 0               | 0.00% (0/5) | 10.50% (2/19) |

\*A specialist nurse from the community attends to do spirometry but does not have a system one template, however one is currently being identified for use.

### 5.2.2.4 Diabetes

In male prisoners the overall prevalence of non-insulin dependent diabetes is 0.3% and overall prevalence of insulin dependent diabetes is 0.5%.<sup>27</sup> However studies carried out in a male prison found that 8% of the population were diabetic and could imply that diagnosed diabetes is 2-8 times that of the general population.<sup>28</sup> Prevalence of NIDDM increases with age therefore it is expected that those prisons with a greater percentage of older prisoners will have a greater number of individuals with diabetes.

The national prevalence of diabetes amongst the 17+ population is 5.4% (QoF 09/10).

**Table 13: Expected Number of prisoners with Diabetes**

| Ischemic Heart Disease |     | Prevalence (%) Male prisoners IDDM | Prevalence (%) Male prisoners NIDDM | Estimated numbers Lancaster Farms       |   | Estimated numbers Kirkham |   | Estimated numbers Garth |   | Estimated numbers Wymott |   | Estimated numbers Preston |   |
|------------------------|-----|------------------------------------|-------------------------------------|---|---|---------------------------|---|-------------------------|---|--------------------------|---|---------------------------|---|
|                        |     |                                    |                                     | Operational capacity - Total Population |   |                           |   |                         |   |                          |   |                           |   |
| Age range              |     |                                    |                                     | 530                                     |   | 592                       |   | 847                     |   | 1176                     |   | 800                       |   |
| 16-24                  | 0.3 | 0.0                                |                                     | 2                                       | 0 | 0                         | 0 | 0                       | 0 | 0                        | 0 | 0                         | 0 |
| 25-34                  | 0.5 | 0.1                                |                                     |   |   | 1                         | 0 | 2                       | 0 | 2                        | 0 | 2                         | 0 |
| 35-44                  | 0.6 | 0.3                                |                                     |   |   | 1                         | 1 | 2                       | 1 | 2                        | 1 | 2                         | 1 |
| 45 - 54                | 0.6 | 1.0                                |                                     |   |   | 2                         | 2 | 1                       | 2 | 2                        | 3 | 1                         | 2 |
| 55-64                  | 0.9 | 2.8                                |                                     |   |   | 0                         | 1 | 1                       | 2 | 1                        | 4 | 0                         | 1 |
| > 64                   | 1.1 | 4.2                                |                                     |   |   | 0                         | 0 | 0                       | 0 | 0                        | 0 | 0                         | 0 |
| Total in pop           | 0.5 | 0.3                                |                                     |   |   |                           |   |                         |   |                          |   |                           |   |
| TOTAL*                 |     |                                    |                                     | 2                                       |   | 8                         |   | 11                      |   | 15                       |   | 9                         |   |
| Actual                 |     |                                    |                                     | 8                                       |   | 21                        |   |                         |   |                          |   |                           |   |

\*Numbers are rounded up or down.

<sup>27</sup> Marshall T, Simpson S and Stevens A. Health care in prisons: a health care needs assessment. Department of Public Health and epidemiology, University of Birmingham,1999

<sup>28</sup> Marshall T, Simpson S and Stevens A. Health care in prisons: a health care needs assessment. Department of Public Health and epidemiology, University of Birmingham,1999

**Table 14: Prisons QoF Diabetes prevalence**

| Diabetes                                       | Target Range | Garth          | Kirkham     | Lancaster Farms | Preston      | Wymott         |
|--|--------------|----------------|-------------|-----------------|--------------|----------------|
| DM02 - BMI recorded in the last 15 months      | 40-90%       | 13.00% (3/23)  | 93.7% 15/16 | 100%            | 16.60% (1/6) | 43.10% (19/44) |
| DM05 - Patient's with HbA1c or equivalent      | 40-90%       | 60.80% (14/23) | 100% 16/16  | 100%            | 16.60% (1/6) | 84.00% (37/44) |
| DM09 - Peripheral pulse                        | 40-90%       | 8.60% (2/23)   | 28.55% 4/14 | 2               | 0.00% (0/6)  | 32.50% (14/43) |
| DM10 - Neuropathy testing                      | 40-90%       | 8.60% (2/12)   | 86.6% 13/15 | 1               | 0.00% (0/6)  | 26.10% (11/42) |
| DM11 - Blood pressure in the last 15 months    | 40-90%       | 52.10% (12/23) | 100% 16/16  | 100%            | 50.00% (3/6) | 90.90% (40/44) |
| DM12 - BP in the last 15 months <145/8         | 40-60%       | 45.40% (10/22) | 100% 14/14  | 0               | 40.00% (2/5) | 62.70% (27/43) |
| DM13 - Micro-albuminuria testing0              | 40-90%       | 4.50% (1/22)   | 15.3% 2/13  | 0               | 0.00% (0/6)  | 30.00% (12/40) |
| DM15 - Proteinuria or micro-albuminuria        | 40-80%       | 0.00% (0/1)    | 0% 0        | 0               | 0.00% (0/0)  | 0.00% (0/3)    |
| DM16 - Total cholesterol in the last 15 months | 40-90%       | 69.50% (16/23) | 93.3% 14/15 | 0               | 33.30% (2/6) | 86.30% (38/44) |
| DM17 - Total cholesterol < 5mmol/l             | 40-70%       | 54.50% (12/22) | 83.3% 10/12 | 0               | 40.00% (2/5) | 63.60% (28/44) |
| DM18 - Influenza immunisation                  | 40-85%       | 0.00% (0/23)   | 69.2% 9/12  | 2               | 0.00% (0/6)  | 0.00% (0/39)   |
| DM19 - Diabetes Register                       |              | 2.60% (23)     | 16          | 100%            | 0.60% (6)    | 3.60% (44)     |
| DM21 - Retinal screening                       | 40-90%       | 30.40% (7/23)  | 100% 13/13  | 1               | 0.00% (0/6)  | 9.50% (4/42)   |
| DM22 - eGFR or serum creatinine                | 40-90%       | 65.20% (15/23) | 100% 15/15  | 0               | 33.30% (2/6) | 81.80% (36/44) |
| DM23 - Patients with HbA1c < 7.0 or equivalent | 40-50%       | 30.40% (7/23)  | 85.7 6/7    |                 | 20.00% (1/5) | 37.20% (16/43) |
| DM24 - Patients with HbA1c < 8.0 or equivalent | 40-70%       | 34.70% (8/23)  | 88.8% 8/9   |                 | 20.00% (1/5) | 53.40% (23/43) |
| DM25 - Patients with HbA1c < 9.0 or equivalent | 40-90%       | 43.40% (10/23) | 91.6% 11/12 |                 | 20.00% (1/5) | 58.10% (25/43) |

### 5.2.2.5 Coronary Vascular Disease

Cardiovascular disease (CVD) is the leading cause of death in England and Wales. In 2005, CVD was the cause of one in three deaths, accounting for 124,000 deaths; 39,000 of those who died were younger than 75.<sup>29</sup> For every one fatality, there are at least two people who have a major non-fatal CVD event.

CVD predominantly affects people older than 50 and age is the main determinant of risk. Apart from age and sex, three modifiable risk factors – smoking, raised blood pressure and raised cholesterol – make a major contribution to CVD risk, particularly in combination. These account for 80% of all cases of premature coronary heart disease (CHD). In male prisoners the prevalence of ischemic heart disease is reported to be 0.0% 0.5% 0.8% 4.5% 15.5% amongst 16-24, 25-34, 35-44, 45-54 and 55-64 year olds, respectively.<sup>30</sup>

**Table 15: Expected Number of prisoners with coronary vascular disease**

| Ischemic Heart Disease                         | Prevalence (%) Males England | Prevalence (%) Male prisoners | Estimated numbers Lancaster Farms | Estimated numbers Kirkham | Estimated numbers Garth | Estimated numbers Wymott | Estimated numbers Preston |
|--|------------------------------|-------------------------------|-----------------------------------|---------------------------|-------------------------|--------------------------|---------------------------|
| <b>Operational capacity - Total Population</b> |                              |                               |                                   |                           |                         |                          |                           |
| Age range                                      |                              |                               | <b>530</b>                        | <b>630</b>                | <b>847</b>              | <b>1176</b>              | <b>800</b>                |
| 16-24  | 0.0                          | 0.0                           | 0                                 | 0                         | 0                       | 0                        | 0                         |
| 25-34  | 0.3                          | 0.5                           | 0                                 | 1                         | 2                       | 2                        | 2                         |
| 35-44  | 0.5                          | 0.8                           | 0                                 | 2                         | 2                       | 3                        | 2                         |
| 45 - 54  | 3.0                          | 4.5                           | 0                                 | 9                         | 9                       | 13                       | 10                        |
| 55-64  | 10.3                         | 15.5                          | 0                                 | 5                         | 8                       | 25                       | 4                         |
| Total in pop                                   | 0.5                          | 0.7                           |                                   |                           |                         |                          |                           |
| <b>TOTAL*</b>                                  |                              |                               | <b>0</b>                          | <b>17</b>                 | <b>21</b>               | <b>43</b>                | <b>18</b>                 |
| <b>Actual</b>                                  |                              |                               | <b>0</b>                          | <b>11</b>                 |                         |                          |                           |

\*Total number is rounded.

**Table 16: Prisons QoF Coronary Heart Disease prevalence**

| Cardiovascular Disease Primary Prevention | Target Range | Garth        | Kirkham     | Lancaster Farms | Preston      | Wymott       |
|---|--------------|--------------|-------------|-----------------|--------------|--------------|
| CVD PP01 - CVD risk assessment            | 40-70%       | 33.30% (1/3) | 29.9% 12/43 | 0               | 0.00% (0/9)  | 9.00% (1/11) |
| CVD PP02 - CVD lifestyle advice           | 40-70%       | 0.00% (0/16) | 7.8% 4/51   | 0               | 9.00% (1/11) | 6.20% (2/32) |
| CVD Register                              |              | 1.80% (16)   | 79          | 0               | 1.10% (9)    | 2.60% (32)   |

<sup>29</sup> [http://www.statistics.gov.uk/downloads/theme\\_health/hsq33web.pdf](http://www.statistics.gov.uk/downloads/theme_health/hsq33web.pdf)

<sup>30</sup> Marshall T, Simpson S and Stevens A. Health care in prisons: a health care needs assessment. Department of Public Health and epidemiology, University of Birmingham, 1999

| Coronary heart disease register                    | Target Range | Garth          | Kirkham     | Lancaster Farms | Preston      | Wymott         |
|--|--------------|----------------|-------------|-----------------|--------------|----------------|
| CHD01 - Coronary heart disease register            |              | 1.90% (17)     | 14          | 0               | 0.70% (7)    | 3.70% (45)     |
| CHD02 - Referred for exercise testing              | 40-90%       | 28.50% (2/7)   | 33.3% 1/3   | 0               | 25.00% (1/4) | 17.30% (4/23)  |
| CHD05 - Blood pressure reading in last 15m         | 40-90%       | 76.40% (13/17) | 100% 14/14  | 0               | 71.40% (5/7) | 86.60% (39/45) |
| CHD06 - BP < 150/90 in last 15m                    | 40-70%       | 70.50% (12/17) | 100% 14/14  | 0               | 57.10% (4/7) | 65.90% (29/44) |
| CHD07 - Total cholesterol in previous 15 months    | 40-90%       | 64.70% (11/17) | 100% 14/14  | 0               | 57.10% (4/7) | 73.30% (33/45) |
| CHD08 - Total cholesterol <= 5 mmol/l              | 40-70%       | 47.00% (8/17)  | 100% 11/11  | 0               | 42.80% (3/7) | 51.10% (23/45) |
| CHD09 - CHD therapy in last 15 months              | 40-90%       | 5.80% (1/17)   | 100% 14/14  | 0               | 42.80% (3/7) | 44.40% (20/45) |
| CHD10 - CHD treated with beta blockers             | 40-60%       | 0.00% (0/17)   | 61.5% 8/13  | 0               | 0.00% (0/7)  | 0.00% (0/43)   |
| CHD11 - History of myocardial infarction, ACE inh  | 40-80%       | 0.00% (0/0)    | 05          | 0               | 0.00% (0/0)  | 0.00% (0/0)    |
| CHD12 - Influenza immunisation                     | 40-90%       | 0.00% (0/17)   | 85.7% 12/14 | 0               | 0.00% (0/7)  | 0.00% (0/42)   |
| Stroke And Transient Ischaemic Attacks (TIA)       | Target Range | Garth          | Kirkham     | Lancaster Farms | Preston      | Wymott         |
| STROKE01 - Register                                |              | 0.10% (1)      | 3           | 0% (1)          | 0.40% (4)    | 0.50% (7)      |
| STROKE05 - BP in the last 15 months                | 40-90%       | 0.00% (0/1)    | 100% 3/3    | 0               | 75.00% (3/4) | 71.40% (5/7)   |
| STROKE06 - BP < 150/90                             | 40-70%       | 0.00% (0/1)    | 100% 3/3    | 0               | 50.00% (2/4) | 57.10% (4/7)   |
| STROKE07 - Total cholesterol in the last 15 months | 40-90%       | 100.0% (1/1)   | 100% 3/3    | 0               | 50.00% (2/4) | 57.10% (4/7)   |
| STROKE08 - Total cholesterol < 5 mmol/l            | 40-60%       | 100.0% (1/1)   | 100% 3/3    | 0               | 50.00% (2/4) | 57.10% (4/7)   |
| STROKE10 - Influenza immunisation                  | 40-85%       | 0.00% (0/1)    | 33.3% 1/3   | 0               | 0.00% (0/4)  | 0.00% (0/7)    |
| STROKE12 - Non-haemorrhagic stroke                 | 40-90%       | 0.00% (0/0)    | 100% 2/2    | 0               | 50.00% (1/2) | 0.00% (0/3)    |
| STROKE13 - Referred for further investigation      | 40-80%       | 0.00% (0/1)    | 0           | 0               | 0.00% (0/0)  | 0.00% (0/0)    |

### 5.2.2.6 Cancer

The national prevalence of cancer is 1.4% (QoF 09/10).

Prostate cancer is the most common cancer and the second most common cause of cancer-related deaths in men in the UK. In 2005, a total of 34,302 men were diagnosed with prostate cancer, and, in 2006, 10,038 men died from the disease. The most common cause of cancer-related deaths is lung cancer, which was diagnosed in 22,259 men in 2005 and which claimed the lives of 19,600 men in 2006.

<sup>31</sup>

Testicular cancer is a relatively rare cancer with 2,138 new cases registered in 2008 in the UK. It is responsible for just over 1% of all male cancers and occurs most commonly in young and middle-aged men. Around half (47%) of all cases occur in men under 35 years and over 90% occur in men under 55 years. Testicular cancer rarely occurs before puberty but it is the most common cancer in men aged 15-44 years. Incidence rates peak at around 17 or 18 per 100,000 in the 25-34 age group. It has been estimated that the lifetime risk of developing testicular cancer in 2008 is 1 in 199 for men in the UK. <sup>32</sup>

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year. <sup>33</sup>

However prevalence of most cancers increases with age. There is very little published on the subject of cancer in older prisoners. It could however be hypothesised that risky lifestyles and behaviour would mean that older prisoners are more at risk of certain types of cancer compared with the community based population. <sup>34</sup>

**Table 17: Prisons QoF Cancer prevalence**

| Cancer                                   | Target Range | Garth          | Kirkham | Lancaster Farms | Preston        | Wymott         |
|--|--------------|----------------|---------|-----------------|----------------|----------------|
| CANCER01 - Cancer register               |              | 0.10%<br>(1)   | 2       | 1               | 0.20%<br>(2)   | 0.10%<br>(2)   |
| CANCER03 - Review within 6m of diagnosis | 40-90%       | 0.00%<br>(0/1) | 0       | 1               | 0.00%<br>(0/1) | 0.00%<br>(0/0) |

<sup>31</sup> Cancer Research UK. *Prostate CancerStats 2008*. 2008.

<sup>32</sup> <http://info.cancerresearchuk.org/cancerstats/types/testis/incidence/>

<sup>33</sup> Cancer Research UK, 2005. Cancerstats

<sup>34</sup> Docherty J. Prison Health Research Network. The Healthcare Challenges of older people in prisons – a briefing paper.



## 5.3 Communicable diseases

The prevalence of infectious diseases (particularly HIV and AIDS, hepatitis and tuberculosis) is often much higher in prisons than outside, often related to injecting drug use and other lifestyle behaviours.<sup>35</sup>

### 5.3.1 Blood borne viruses – HIV, Hepatitis B and Hepatitis C

In sentenced prisoners, the prevalence of hepatitis B and C is 8% and 9%, respectively<sup>36</sup>, for YOI's the rate is significantly lower at 4% and 1% respectively. Hepatitis C viral (HCV) infection is a significant public health problem and prisoners have a high prevalence of hepatitis C virus (HCV) infection compared with the general population in England and Wales.<sup>37</sup>

Prevalence of HIV amongst adult male prisoners is estimated at 0.3%<sup>38</sup>

**Table 18: Expected Number of prisoners with Blood Borne Viruses**

| Blood Borne Viruses | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms        | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|---------------------|----------------|--|-------------------------------|-----------------------------|------------------------------|-------------------------------|
|                     |                | <b>Operational capacity - Total Population</b> |                               |                             |                              |                               |
|                     |                | <b>530</b>                                     | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| Hep B               | 8% (YOI 4%)    | 21   | 50                            | 68                          | 92                           | 64                            |
| Hep C               | 9% (YOI 1%)    | 5  | 57                            | 76                          | 106                          | 72                            |
| <b>TOTAL</b>        |                | <b>26</b>                                      | <b>107</b>                    | <b>144</b>                  | <b>198</b>                   | <b>136</b>                    |
| HIV                 | 0.3%           | 0  | 2                             | 3                           | 3                            | 2                             |

\*Total number is rounded.

<sup>35</sup> World Health Organisation. Health in prisons A WHO guide to the essentials in prison health, 2007

<sup>36</sup> (Marshall T, Simpson S and Stevens A. Health care in prisons: a health care needs assessment. Department of Public Health and epidemiology, University of Birmingham, 1999).

<sup>37</sup> Sutton, A. J. and Edmunds, W. J. and Sweeting, M. J. and Gill, O. N. (2008). The cost-effectiveness of screening and treatment for hepatitis C in prisons in England and Wales: a cost-utility analysis. JOURNAL OF VIRAL HEPATITIS, 15 (11). pp. 797-808. ISSN 1352-0504

<sup>38</sup> Prevalence of HIV in England and Wales in 1997: Annual Report of the Unlinked Anonymous Prevalence Monitoring Programme 1998 (Prison based survey)(figures relate to those expected to have antibodies to Hep B or Hep C in their blood, i.e. indicates previous exposure to infection – not those with acute or chronic hepatitis

### 5.3.2 Sexually transmitted infections

There are no direct estimates of prevalence of other sexually transmitted infections in the UK prison population however there are some studies with rates of newly diagnosed STIs.<sup>39</sup> Prisoners are likely to have a higher incidence of these infections than the wider population. The incidence of sexually transmitted disease has continued to increase in the UK over the past decade, particularly among young people. Many STIs remain undiagnosed and untreated.

**Table 19: Expected number of prisoners with STIs**

| STI        | Prevalence (%) |      | Estimated numbers HMYOI Lancaster Farms        | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|------------|----------------|------|--|-------------------------------|-----------------------------|------------------------------|-------------------------------|
|            |                | YOI  | <b>Operational capacity - Total Population</b> |                               |                             |                              |                               |
|            |                |      | <b>530</b>                                     | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| Syphilis   | 0.06           | 0.06 | 0  | 0                             | 1                           | 1                            | 1                             |
| Gonorrhoea | 6.6            | 8.7  | 46   | 42                            | 56                          | 78                           | 53                            |
| Chlamydia  | 15.9           | 22.7 | 120  | 100                           | 135                         | 187                          | 127                           |
| Herpes     | 4.8            | 3.7  | 20   | 30                            | 41                          | 57                           | 38                            |
| Warts      | 26.3           | 31.7 | 168  | 166                           | 223                         | 309                          | 210                           |

With regards to risk factors for STIs, over 80% of young people in the Farms are expected to have unprotected sex in the past year with two or more partners, compared to 55% of prisoners in adult prisons. Whilst STIs are more common in young people (23% and 32% of young people in the Farms expected to be infected with Chlamydia and warts respectively), the prevalence is also common in adult prisons.

### 5.3.3 Tuberculosis

Currently there is no reliable information on TB diagnosis in prison however prisoners are a higher risk group for TB than the population in general because of their social and lifestyle profile.

Between 2004 and 2006, 152 prisoners were identified with TB through the national enhanced TB Surveillance (ETS) system, laboratory surveillance (MycobNet) and a TB in prisons surveillance pilot underway in London. This gives a crude incidence rate of 66 cases / 100,000 prisoners per year, although this is likely to be an

<sup>39</sup> PHLS Sexually transmitted infections 1999 [www.phls.co.uk/facts/std-t01.htm](http://www.phls.co.uk/facts/std-t01.htm)

underestimate. Using ETS, 6 cases of TB in North West prisons can be identified from 2000-2006.<sup>40</sup> Prisoners have been found to be more likely to have pulmonary disease than the general population (75% vs 56%) and are all more likely to have drug resistant TB<sup>41</sup>

#### 5.3.4 Gastrointestinal disease

It is not possible to estimate the number of potential gastrointestinal infections in the Lancashire prisons however nationally a number of gastrointestinal (GI) disease outbreaks occurred simultaneously in the prison estate in late December and early January 2009/10. In 2009, of the 12 reported outbreaks, seven were caused by *Norovirus*, one by *Clostridium perfringens*, one by *Cryptosporidium* and one by *Salmonella* O9 g (*enteritidis*) Phage Type 4. The salmonella outbreak was the largest, with over 300 prisoners showing symptoms of diarrhoea and/or vomiting

#### 5.3.5 Influenza

Prisons run the risk of potentially more serious outbreaks of influenza due to:

- Large numbers of individuals living in close proximity
- Large population turn over
- Access to healthcare facilities could be limited when demand is high
- Prisoners have a higher prevalence of respiratory infection and immunosuppression and other chronic illness than those in the wider community
- Increasing number of older prisoners and those with long term conditions.

#### 5.4. Immunisation and Vaccination

Many British born prisoners miss out on their routine childhood immunisations and other required vaccines whilst foreign born prisoners may not have been exposed to

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<sup>40</sup> HPA NW: (2008) TB Policy for Prisons in the North West : Available from: [http://www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1223971263063](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1223971263063)

<sup>41</sup> Anderson C, et al (2010) **Tuberculosis in UK prisoners: a challenge for control** *J Epidemiol Community Health* 2010;**64**:373-376

common childhood disease in the UK and may not have been vaccinated in childhood. For further information please refer to the Immunisation and vaccination HNA for North Lancashire prisons. (2010/11)

## 5.5 Special senses and Disability

The Prison Reform Trust estimates that:

- 15% of people in prison report a disability.
- 20 -30% of all offenders have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system.
- 23% of young offenders have learning difficulties (IQ below 70) and 36% borderline learning difficulties (IQ 70-80%)<sup>42</sup>

**Table 20: Expected Number of prisoners with disability**

| Disability                                     | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|--|----------------|---|-------------------------------|-----------------------------|------------------------------|-------------------------------|
| <b>Operational capacity - Total Population</b> |                |   |                               |                             |                              |                               |
|  |                | <b>530</b>                              | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| LD   | 25% (YOI 23)   | 122                                     | 158                           | 212                         | 286                          | 200                           |
| Borderline LD                                  | YO36%          | 191                                     |                               |                             |                              |                               |
| Reported disability                            | 15%            | 80                                      | 95                            | 127                         | 172                          | 120                           |
| <b>Actual</b>                                  |                | 22%                                     | 17                            |                             |                              |                               |

LF - 22% of young men enter with learning disabilities

Kirkham – 17 men indicate they have a disability

As the prison population increases with age it is expected that more prisoners will have or develop physical and mental disabilities. The incidence of cerebrovascular disease and therefore dementia is likely to be higher in the prison population compared with the older community population, largely due to the increased risk factors found in the older prison population.<sup>43</sup>

<sup>42</sup> Prison Reform Trust Bromley Briefings Prison Factfile *December 2010* Accessed 18/04/11 at: <http://www.prisonreformtrust.org.uk/uploads/documents/FactFileJuly2010.pdf>

<sup>43</sup> Fazel S. McMillan J. and Odonnell I (2002) Dementia in prison: Ethical and Legal Implications. *Journal of Medical Ethics* Vol.28, pp156-159

Individuals with learning disabilities have poorer health than their non-disabled peers, having a shorter life expectancy and increased risk of premature death.<sup>44</sup> They are also less able to cope with the criminal justice system.

## 5.6. Mental health and well being

***‘There is particularly urgent need for increased provision for the care of those with mental health problems, who make up a larger proportion of the prison population than they would of any other group in the community. What is more, prison can exacerbate mental health problems, which has a long-term impact on the individual concerned and the community into which he or she may be released.’***

**HM Chief Inspector of Prisons, *Patient or prisoner*, 1996**

### 5.6.1 Policy

The Bradley Report<sup>45</sup> recognises that there are now more people with mental health problems in prison than ever before. While public protection remains the priority, there is a growing consensus that prison may not always be the right environment for those with severe mental illness. Custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide.

The policy of ‘diversion’ for people with mental health problems or learning disabilities has been supported by Government since as far back as 1990. But the lack of a nationally guided approach has meant that implementation has been inconsistent. In recent years, policy developments across both the health and criminal justice sectors have created a much more receptive background for implementing this diversion approach. For example, offenders are now recognised as part of a socially excluded population.

Despite the introduction in recent years of trained healthcare professionals, the transfer of provision to the National Health Service, and the indirect better understanding of mental illness among prison staff, there still appear to be sizeable

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<sup>44</sup> Emerson E. Baines S. 2010 Health Inequalities & People with learning disabilities in the UK: 2010. Learning Disabilities Observatory and Department health London.

<sup>45</sup> The Bradley Report, 2009. Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system

gaps in provision and too much unmet and sometimes unrecognised mental health need in prisons.

Often those who end up in prisons have complex and long-standing mental health needs: often linked to substance misuse, and ranging from acute psychosis, through personality disorder, to high levels of anxiety and depression. Some prisoners also, or alternatively, have learning disabilities. And these needs are themselves only part of a more complex picture of multiple disadvantage and social exclusion, which may fall through the net of community health, social care, housing and drugs agencies.

Primary care is the first point of service user contact with the NHS and is delivered by a wide range of professionals, including GPs, nurses, dentists, mental health workers, pharmacists and opticians (NHS, 2006). Primary care focuses on the treatment of routine injuries and illnesses as well as preventative care, and is concerned with a patient's general health needs. Less severe mental health problems such as depression, stress or anxiety can be treated by a GP and/or other primary care services, including primary care mental health workers of various disciplines.

The principles of prison primary care include moving health care closer to the patient wherever possible, shifting the emphasis away from hospital-based treatments, including chronic disease management in the community, more preventative care, better health education, and encouragement of patient self awareness. For prisons, the emphasis is on the management of mental illness within the prison – analogous to the model of community treatment – where possible.

Much of the prevalence of psychiatric disorders in prisons are those for which treatment is generally provided by mental health workers at the primary care level. At present, it appears that these prisoners are unlikely to be identified or to receive services.

The Mental Health Act (1983) Section 2 defines mental disorder as, “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind”.

Within England and Wales the prison population is approaching 80,000, with overcrowding being a constant – and widely reported - problem. Mental health is a

major concern, with high numbers of prisoners having a mental disorder, substance misuse problem, or both; one UK study estimated that the figures may be as high as 90% (Cinamon & Bradshaw, 2005).

### 5.6.2 Prevalence Studies

One of the largest epidemiological studies amongst the prison population in the UK prior to the integration of prison healthcare arrangements with the NHS was that of Singleton, Meltzer, Gatward, Coid and Deasy (1998). They conducted over 3000 interviews with male and female prisoners, both remanded and sentenced, across 131 UK establishments, assessing for a range of disorders, using standardised measures. Singleton *et al* (1998) concluded that a large proportion of all the prisoners in the sample had several mental disorders, stating that one in ten, or fewer, showed no evidence of any of the disorders considered in the survey.

For the psychosis assessments, lay interviews identified the prevalence of functional psychosis as 9% for male (remand), 4% for male (sentenced). Neurotic disorders were identified for 59% of male (remand), 40% of male (sentenced). The results obtained from the intellectual functioning screen indicated that most participants scored below the average.

Substance abuse is often coupled with mental health problems. There is a considerable body of evidence which indicates high rates of alcohol and drug dependence in prison populations (e.g. Fazel & Danesh, 2002, Magruder, Sonne, Brady, Quello, & Herbert, 2005). Much research has used self-report measures, and prisoners are often unlikely to disclose this information; the actual prevalence of misuse and dependence may be higher than that recorded. It is an area that, although widely researched, continues to need exploration.

Singleton *et al* discovered that 63% of male sentenced prisoners were identified as potentially alcohol dependent 43% of male sentenced prisoners were identified as drug dependent.

Fazel and Danesh (2002)<sup>46</sup> carried out a systematic review of surveys investigating serious mental disorder in a total of 23,000 prisoners. They reviewed 62 surveys from

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<sup>46</sup> Fazel S, Danesh J. Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *Lancet* [serial online]. 2002 [cited 2007 April 27] ;359:545-550.

12 countries, in Europe, Australasia, the UK and the US. They searched for psychiatric surveys that were based on interviews of randomly selected prisoners, i.e. not those who had been referred to prison psychiatric services, and included diagnoses of psychotic illnesses or major depression within the previous 6 months, or any history of personality disorder.

The review found that 3.7% of male prisoners, met the criteria for a diagnosis of psychotic illness. A total of 10% had major depression, and 65% had a personality disorder, including 47% with antisocial personality disorder. The authors concluded that, in comparison to the general population, prisoners were several times more likely to have psychosis and / or major depression, and were more likely to have antisocial personality disorder.

There is currently no clear blueprint for delivering mental healthcare in prisons, based upon the assessed needs of the prison population. There is, in particular, a gap in the organisation and provision of specialised primary mental healthcare, appropriate to the complex and challenging needs of those in prison who fall beneath the threshold of severe and enduring illness, and who may be particularly at risk of suicide or self-harm. Mental health in-reach teams often work in isolation - rarely well-integrated with other services being provided to their clients within prisons. Improvements must be made in the essential links with residential staff providing day-to-day care, those supporting suicidal and self-harming or segregated prisoners, forensic psychologists offering cognitive behaviour programmes, and resettlement teams.

Improvements are also required in joint work between mental health and substance misuse teams - particularly given the well-established connection between substance misuse and mental illness – including the psycho-social support for the initial clinical management of drug and alcohol dependent prisoners.



**Table 21: The estimated prevalence of mental health problems in adult male prisoners.**

| Mental disorders                               | Prevalence (%) | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|--|----------------|-------------------------------|-----------------------------|------------------------------|-------------------------------|
| <b>Operational capacity - Total Population</b> |                |                               |                             |                              |                               |
|  |                | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| Personality disorder                           | <b>64</b>      | 403                           | 542                         | 732                          | 512                           |
| Functional Psychoses                           | <b>7</b>       | 44                            | 59                          | 80                           | 56                            |
| Sleep Disorders                                | <b>54</b>      | 340                           | 457                         | 618                          | 432                           |
| Somatic symptoms                               | <b>16</b>      | 101                           | 136                         | 183                          | 128                           |
| Physical health worries                        | <b>16</b>      | 101                           | 136                         | 183                          | 128                           |
| Post-traumatic stress disorder                 | <b>3</b>       | 19                            | 25                          | 34                           | 24                            |
| Mixed anxiety & depression                     | <b>19</b>      | 120                           | 161                         | 217                          | 152                           |
| Generalised Anxiety Disorder                   | <b>8</b>       | 50                            | 68                          | 92                           | 64                            |
| Depressive episode                             | <b>8</b>       | 50                            | 68                          | 92                           | 64                            |
| Phobias  | <b>6</b>       | 38                            | 51                          | 69                           | 48                            |
| Obsessive-Compulsive Disorder                  | <b>7</b>       | 44                            | 59                          | 80                           | 56                            |
| Panic Disorder                                 | <b>3</b>       | 19                            | 25                          | 34                           | 24                            |
| <b>Any neurotic disorder</b>                   | <b>40</b>      | <b>252</b>                    | <b>339</b>                  | <b>458</b>                   | <b>320</b>                    |
| <b>Self-harm and suicide</b>                   |                |                               |                             |                              |                               |
| Suicidal thoughts (past week)                  | <b>4</b>       | 25                            | 34                          | 46                           | 32                            |
| Non-suicidal self-harm                         | <b>7</b>       | 44                            | 59                          | 80                           | 56                            |

## Lancaster Farms

There is strong evidence that young offenders differ in their patterns of mental disorder – in particular, they are more likely than older prisoners to suffer from personality disorder. It was felt, therefore, that there was a need for more detailed consideration of the psychiatric morbidity of young offenders included in the ONS survey of prisoners. This prevalence table uses data from a report commissioned by the Department of Health which includes further analysis on psychiatric morbidity among young offenders in England and Wales.<sup>47</sup>

<sup>47</sup> *Psychiatric Morbidity among Young Offenders in England and Wales; Deborah Lader, Nicola Singleton and Howard Meltzer London: Office for National Statistics*

**Table 22 The estimated prevalence of mental health problems in YOI.**

| Mental disorders               | Prevalence (%) | Estimated numbers Lancaster Farms        |
|--------------------------------|----------------|--|
|                                |                | Total Operational Capacity<br><b>530</b> |
| Personality disorder           | <b>85</b>      | 439                                      |
| Functional Psychoses           | <b>8</b>       | 41                                       |
| Sleep Disorders                | <b>60</b>      | 310                                      |
| Somatic symptoms               | <b>23</b>      | 119                                      |
| Physical health worries        | <b>22</b>      | 114                                      |
| Post-traumatic stress disorder | <b>23</b>      | 119                                      |
| Mixed anxiety & depression     | <b>21</b>      | 109                                      |
| Generalised Anxiety Disorder   | <b>8</b>       | 41                                       |
| Depressive episode             | <b>10</b>      | 52                                       |
| Phobias                        | <b>25</b>      | 129                                      |
| Obsessive-Compulsive Disorder  | <b>9</b>       | 46                                       |
| Panic Disorder                 | <b>3</b>       | 16                                       |
| <b>Any neurotic disorder</b>   | <b>52</b>      | <b>269</b>                               |
| <b>Self-harm and suicide</b>   |                |  |
| Suicidal thoughts (past week)  | <b>7</b>       | 36                                       |
| Non-suicidal self-harm         | <b>9</b>       | 46                                       |

**Table 23 Prisons QoF Mental Health prevalence**

| Mental Health                                    | Target Range | Garth          | Kirkham   | Lancaster Farms | Preston      | Wymott        |
|--|--------------|----------------|-----------|-----------------|--------------|---------------|
| MH04 - Lithium therapy, serum creatinine and TSH | 40-90%       | 0.00% (0/0)    | 0         | 0               | 0.00% (0/0)  | 0.00% (0/0)   |
| MH05 - Lithium levels in therapeutic range       | 40-90%       | 0.00% (0/0)    | 0         |                 | 0.00% (0/0)  | 0.00% (0/0)   |
| MH06 - Comprehensive care plan                   | 25-50%       | 0.00% (0/19)   | 33.3% 1/3 |                 | 0.00% (0/7)  | 8.30% (1/12)  |
| MH07 - Annual review DNA                         | 40-90%       | 0.00% (0/0)    | 0         |                 | (0/0)        | 0.00% (0/0)   |
| MH08 - Register                                  |              | 2.10% (19)     | 4         |                 | 0.70% (7)    | 1.00% (12)    |
| MH09 - Review recorded within last 15 months     | 40-90%       | 57.80% (11/19) | 100% 3/3  |                 | 42.80% (3/7) | 41.60% (5/12) |

| Depression                                     | Target Range | Garth        | Kirkham    | Lancaster Farms | Preston      | Wymott        |
|--|--------------|--------------|------------|-----------------|--------------|---------------|
| DEP01 - Diabetes / heart disease. Case finding | 40-90%       | 0.00% (0/35) | 21.7% 5/23 |                 | 0.00% (0/12) | 12.00% (9/75) |
| DEP02 - Newly diagnosed depression             | 40-90%       | 0.00% (/56)  | 14.2% 3/21 |                 | 0.00% (0/28) | 0.50% (1/175) |
| DEP03 - Depression and assessment              | 40-90%       | 0.00% (0/0)  | 0          |                 | 0.00% (0/0)  | 0.00% (0/7)   |

## 5.7. Lifestyle/risk factors

### 5.7.1 Alcohol and drug misuse

19% of prisoners surveyed by HM Inspectorate of Prisons reported having an alcohol problem when they entered their prison. It was even higher among young adults (30%) and women (29%).<sup>48</sup>

Nearly two-thirds of sentenced male prisoners (63%) and two-fifths of female sentenced prisoners (39%) admit to hazardous drinking which carries the risk of physical or mental harm. Of these, about half have a severe alcohol dependency.<sup>49</sup>

Between a third and a half of new receptions into prison are estimated to be problem drug users (equivalent to between 45,000 and 65,000 prisoners in England and Wales).<sup>50</sup>

**Table 24: Expected number of drug and alcohol users**

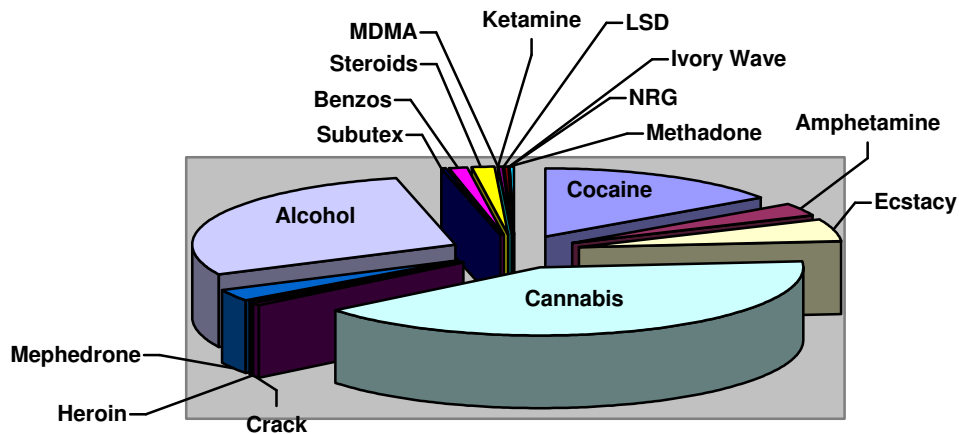
| substance                                      | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|--|----------------|---|-------------------------------|-----------------------------|------------------------------|-------------------------------|
| <b>Operational capacity - Total Population</b> |                |   |                               |                             |                              |                               |
|  |                | <b>530</b>                              | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| Self report Alcohol                            | 19%            | 101                                     | 120                           | 161                         | 217                          | 152                           |
| Drugs  | 33%            | 175                                     | 208                           | 280                         | 378                          | 264                           |
| <b>Actual</b>                                  |                |   |                               |                             |                              |                               |

<sup>48</sup> HM Chief Inspector of Prisons for England and Wales (2010) Alcohol services in prisons: an unmet need, London: HMCIP

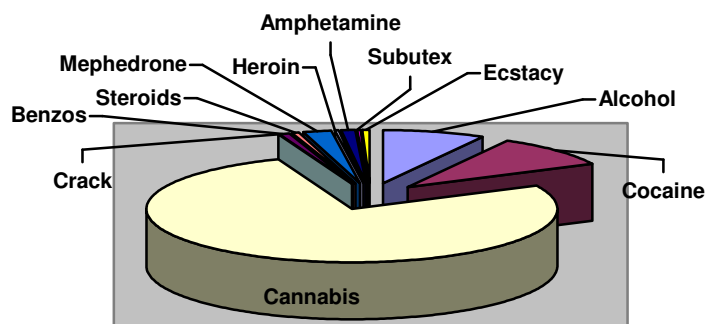
<sup>49</sup> (Prison Reform Trust (2004) Alcohol and reoffending: who cares? London: PRT

<sup>50</sup> UK Drug Policy Commission (2008) Reducing drug use, reducing reoffending, London: UKDPC

A recent study undertaken by CARAT at Lancaster Farms during the induction process identified trends in drug use for their establishment:



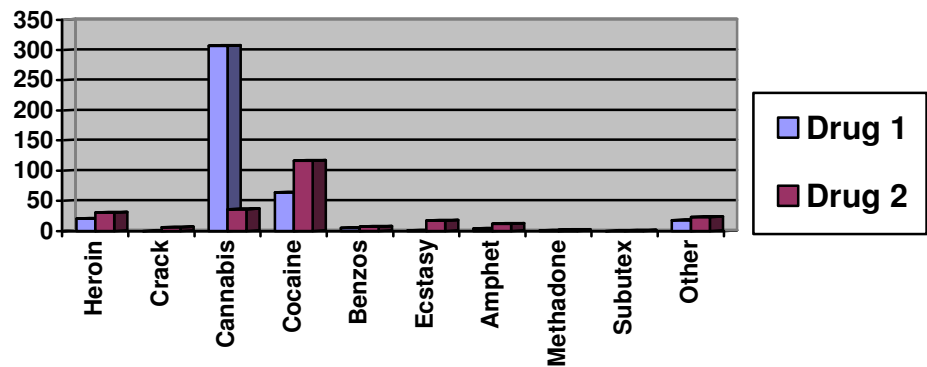
Of these substances, offenders were asked to name their substance of choice. There are shown below.



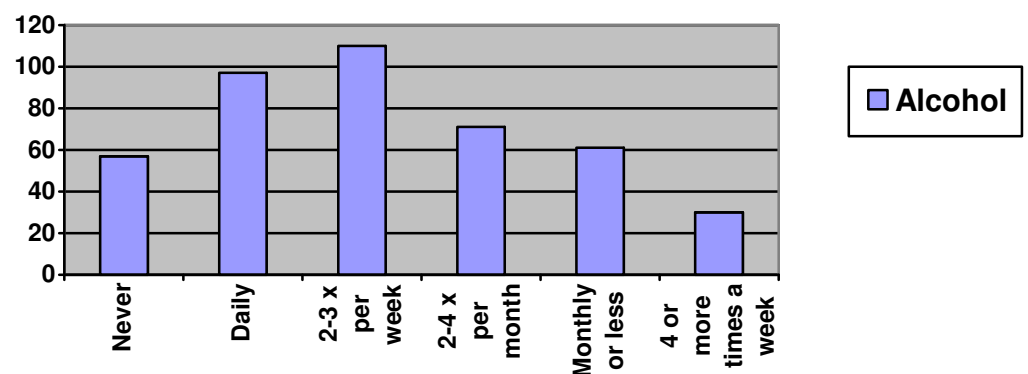
The drug of choice named by offenders seen on induction was cannabis, followed by cocaine and alcohol.

The figures showed that offenders have also declared the use of Mephedrone, Ivory Wave and NRG. This demonstrates a raise in 'legal highs'.

Offenders were asked to state their drug of choice and others used. These are shown in the table below as 'Drug 1' and 'Drug 2'.



While this does not include alcohol, the drug of choice is representative of the data collated from induction, with 307 of the 429 samples declaring Cannabis as drug one and 64 declaring Cocaine. Alcohol use was interrogated and the following figures gathered. The DIR looks at frequency of alcohol use, from never drinking alcohol to daily use.



The majority of those who declared alcohol use stated that they drank between 2 and 3 times per week. This was closely followed by offenders who declared daily use of alcohol. Of the sample, 83% were poly drug users (drugs and alcohol). Only 12% stated that they used drugs only. Of the 83% poly drug users, 64% of these declared the use of two or more drugs as well as alcohol.

## Alcohol

Many offenders are poly users, reporting the use of both drugs and alcohol. When asked during the induction process to name a drug of choice, only 8% stated alcohol. In contract to this, 55% actually reported the use of alcohol alongside other substances. 14% of those seen stated that they only used alcohol.

A survey was completed in April 2010 where 221 prisoners were asked to complete a brief questionnaire. The sample used was randomly selected from the general population. The

aim was to assess the level of need for specific alcohol support and was conducted by the substance misuse team on the request of the Drug Strategy manager. The survey provided the following results:

- 34.4% suggested that alcohol was their primary drug of choice (19.6% in 2009).
- 38.5% suggested that alcohol was their secondary drug of choice (24.7% in 2009).
- 77% drank more than 6 standard drinks on any one occasion (84.7% in 2009).
- 40% are currently in prison due to an alcohol related offence (50% in 2009).
- 62% have been cautioned or arrested whilst under the influence of alcohol (58.3% in 2009).
- 17.6% consumed alcohol every day (17.8% in 2009).
- 34.4% consumed alcohol weekly (38.4% in 2009).
- 12.7% reported no alcohol issues.

During this period, CARATs also collated information, from induction screening, relating to alcohol use, as part of the annual needs analysis. Of the sample used, 266 prisoners declared alcohol use:

- 108 or 40.5% declared daily use of alcohol
- 17 or 6.5% declared 4 or more times weekly use of alcohol
- 85 or 32% declared 2-3 times weekly use of alcohol
- 29 or 11% declared using only alcohol with no other substances

### 5.7.2 Smoking

Smoking is the leading cause of preventable death and disease in the UK. About half of all life-long smokers will die prematurely, losing on average about 10 years of life.<sup>51</sup> For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease.<sup>52</sup>

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<sup>51</sup> Doll R, Peto, R, Boreham J & Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328: 1519 <http://www.bmj.com/content/328/7455/1519.long>

<sup>52</sup> Cigarette smoking-attributable morbidity – United States, 2000. MMWR Weekly Report. 5 Sep. 2003

The estimated prevalence of smoking amongst prisoners is 80%, much higher than the 22% in the general population.<sup>53</sup>

In 2009/10 10,490 quit dates were set in prison with a self reported success rate of 56%.<sup>54</sup>

**Table 25 Estimated numbers of smokers**

|               | Prevalence (%) | Estimated numbers HMYOI Lancaster Farms        | Estimated numbers HMP Kirkham | Estimated numbers HMP Garth | Estimated numbers HMP Wymott | Estimated numbers HMP Preston |
|---------------|----------------|--|-------------------------------|-----------------------------|------------------------------|-------------------------------|
|               |                | <b>Operational capacity - Total Population</b> |                               |                             |                              |                               |
|               |                | <b>530</b>                                     | <b>630</b>                    | <b>847</b>                  | <b>1176</b>                  | <b>800</b>                    |
| Smokers       | 80%            | 424  | 504                           | 678                         | 915                          | 640                           |
| <b>Actual</b> |                |  |                               |                             |                              |                               |

### 5.7.3 Obesity

Body Mass Index is a widely used measure of obesity however there are few available studies regarding the prevalence of obesity in the prison population. A survey in 1994 found that male prisoners were more likely to be classed as a desirable weight or under weight and less likely to be classified as overweight or obese.<sup>55</sup>

### 5.7.4 Hypertension

In the UK, about half of people over 65, and about 1 in 4 middle aged adults, have high blood pressure. It is less common in younger adults. Most cases are mildly high (up to 160/100 mmHg). However, *at least* 1 in 20 adults have blood pressure of 160/100 mmHg or above. High blood pressure is more common in people:

- With diabetes. About 3 in 10 people with Type 1 diabetes and more than half of people with Type 2 diabetes eventually develop high blood pressure.
- From African-Caribbean origin.
- From the Indian sub-continent.
- With a family history of high blood pressure.

<sup>53</sup> Singleton, N., Meltzer, H., Gatward, R., Coid, J. & Deasy, D. (1998). Psychiatric morbidity among prisoners in England and Wales: the report of a survey carried out in 1997 by Social Survey Division of the Office of National Statistics on behalf of the Department of Health. London: The Stationery Office, 1998

<sup>54</sup> NHSIC 2010 Statistics on NHS Stop Smoking Services England, April 2009 to march 2010

<sup>55</sup> Bridgwood A. 1994 Survey of the Physical Health of Prisoners in Squires N. Strobl J. (ED) 1996 Healthy Prisons A Vision for the Future Report of the first international conference on healthy prisons. Liverpool.

- With certain lifestyle factors. That is, those who: smoke, are overweight, eat a lot of salt, don't eat many fruit and vegetables, don't take enough exercise, drink a lot of coffee (or other caffeine-rich drinks), or drink a lot of alcohol.<sup>56</sup>

The older prison population is at higher risk of hypertension and its related diseases compared with the older community population. The reasons given for this include previous poor lifestyle, smoking, substance misuse and the stress caused by being in prison.<sup>57</sup>

#### 5.7.5 Serum cholesterol

Blood cholesterol has a log-linear relationship to the risk of CHD and is a key modifiable risk factor. It is estimated that in high-income countries blood cholesterol levels in excess of 3.8 mmol/litre are responsible for more than 50% of CVD events<sup>58</sup>

### 5.8 Dental health

'Decayed or unsound teeth' is defined as teeth with visual or cavitated caries (including unrestorable teeth) or those with an unsound restoration. It can be used as an indication of number of persons in need of dental services. In the general population, up to the age of 45 years, adults from lower socio-economic groups are more likely to have decayed or unsound teeth than those from higher social groups.<sup>59</sup>

Table shows that prisoners have on average 4.2 decayed or unsound teeth and approximately 58.0% to 64.7% of prisoners have at least one such tooth. This compares to a national average of 1.5 decayed or unsound teeth per adult and 55% of the population having at least one such tooth.<sup>60</sup>

The amount of untreated dental disease amongst all prisoners is approximately four times greater than the level found in the general population coming from similar social backgrounds.

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<sup>56</sup> Hypertension: management of hypertension in adults in primary care Accessed at: <http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10986>

<sup>57</sup> Docherty J. Prison Health Research Network. The Healthcare Challenges of older people in prisons – a briefing paper.

<sup>58</sup> World Health Organization (2002) *The world health report 2002. Reducing risks, promoting healthy life*. World Health Organisation. [www.who.int/whr/2002/en](http://www.who.int/whr/2002/en)

<sup>59</sup> Adult Dental Survey 1998 - Social Class IV and V

<sup>60</sup> Dental health of prisoners in the north west of England in 2002. *Community Dental Health* 2005 June; 22(2):113-117



**Table 26 Prevalence of Dental Decay**

|   | Prevalence (%) |             | Estimated numbers<br>HMYOI<br>Lancaster<br>Farms | Estimated numbers<br>HMP Kirkham | Estimated numbers<br>HMP Garth | Estimated numbers<br>HMP Wymott | Estimated numbers<br>HMP Preston |
|---|----------------|-------------|--|----------------------------------|--------------------------------|---------------------------------|----------------------------------|
|   |                |             | Operational capacity - Total Population          |                                  |                                |                                 |                                  |
|   | Community      | Prison pop. | <b>530</b>                                       | <b>630</b>                       | <b>847</b>                     | <b>1176</b>                     | <b>800</b>                       |
| Prisoners with one or more decayed or unsound teeth | 55%            | 61.4        | 325  | 387                              | 520                            | 702                             | 491                              |
| Mean number decayed teeth/prisoner                  | 1.5            | 4.2         |  |                                  |                                |                                 |                                  |

## 5.9 Well being

### 5.9.1 The impact of wellbeing

Mental wellbeing is more than the absence of mental illness and to all of us, as individuals it means<sup>61</sup>:

- Realising our own abilities;
- Coping with the normal stresses of life;
- Working productively and fruitfully;
- Making a contribution to our community.

For people in the business of improving health, responding appropriately to mental wellbeing can mean far reaching and long term benefits to populations<sup>62</sup>:

- Improved quality of life;
- Increased uptake of positive health behaviours;
- Increased life expectancy (protection from CHD, diabetes);
- Better quality of life;

<sup>61</sup> Keyes, C. (2007) „Promoting and Protecting Mental Health as Flourishing: A Complementary Strategy for Improving National Mental Health“, *American Psychologist*, 62(2): 95-108.

<sup>62</sup> National Mental Health Development Unit (2009) *National Guidance on Commissioning Public Mental Health and Well-being*, University of Central Lancashire, Preston.

- Higher education attainment;
- Improved economic wellbeing;
- Reduced crime & anti social behaviour;
- Safer communities with less crime;
- Improved workplace productivity, workforce retention and reduced sickness absence.

A range of risk and protective factors exist which impact on well-being:

**Risk Factors:** Social and individual risk factors all impact negatively upon mental health and need to be addressed.

- ***Social factors*** include: housing, unemployment, poor education and income, community violence, stigma and discrimination.
- ***Individual factors*** include poor parenting, abuse, substance misuse, traumatic life events, prison, and lack of support.

**Protective Factors:** need to be developed in balance with addressing risk factors in order to increase an individuals' resilience to dealing with the ordinary stresses of life. Those already with existing mental health problems often need additional input to promote resilience. Protective factors that promote well-being, include:

- ***A supportive and respectful community***, having a home, being engaged with meaningful activity, for example being in employment or volunteering.
- ***Physical health***, including good food, keeping active and sufficient rest.
- ***Life skills***, including parenting skills, emotional intelligence, skills that protect from abuse, and good inter-personal relationship and social skills are important aspects that underpin and promote positive mental well-being.
- ***Accessible support*** with empowering treatments and therapies are key for those experiencing mental health problems, and promote recovery.

### 5.9.2 Creating Supportive Environments

An integrated approach to well-being, which balances addressing risk factors with promoting protective factors is presented at the end of the report. This needs a public

mental health approach to promoting well-being within particular settings and the wider environment, supported by strategies affecting the wider determinants of health.

As identified in section 3.2 (Social characteristics of sentenced prisoners), the prison population is over represented by people experiencing the worst socio-economic backgrounds. Recognising these factors makes it clear that the prison environment has a considerable impact on well-being; concepts of mental illness do not generally encapsulate the range of issues experienced by prisoners – such as stress, difficulty coping, and behavioural difficulties. Investment in public mental health carries significant potential savings by strengthening protective factors and reducing risk factors and therefore impacting on health and social care usage elsewhere in the system.

All people experience changes in their mental health as a result of social, biological, psychological and environmental factors. Some people, approximately one in every four, receive a diagnosis of a mental illness ranging from mild to severe. Maximal mental health for the whole population is a central goal in improving health. Minimal mental health is associated with a range of health damaging behaviours (smoking, drinking, poor diet, alcohol abuse etc). A lack of positive mental health (as opposed to not being mentally ill) is associated with a significant impact on social functioning and health.

Emotional and behavioral problems occurring in childhood can have profound effects on risks in adulthood. These include a higher risk of substance abuse, academic problems, impaired social relationships, cigarette smoking, high-risk sexual behaviour, physical health problems, and depression in adult life. Indeed, there is a thirty-fold increased risk of completed suicide among adults who had behavioural problems

A study by Trzesniewski et al<sup>63</sup>, found that adolescents with low self-esteem had poorer mental and physical health, worse economic prospects, and higher levels of criminal behaviour during adulthood, compared with adolescents with high self-esteem. The long-term consequences of self-esteem could not be explained by adolescent depression, gender, or socioeconomic status. Moreover, the findings held

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<sup>63</sup> (Trzesniewski, Kali H.; Donnellan, M. Brent; Moffitt, Terrie E.; Robins, Richard W.; Poulton, Richie; Caspi, Avshalom *Developmental Psychology*, Vol 42(2), Mar 2006, 381-390.)

when the outcome variables were assessed using objective measures and informant reports; therefore, the findings cannot be explained by shared method variance in self-report data. The findings suggest that low self-esteem during adolescence predicts negative real-world consequences during adulthood.

It is difficult to know exactly how many people experience minimal or poor mental health as not everyone experiencing such difficulties will seek or receive diagnosis or treatment. The Office for National Statistics (ONS) has undertaken a number of surveys looking at mental health in populations across Great Britain and England. There is a need to build and strengthen the resilience of individuals in the wider community, including those who may be particularly at risk of mental health problems – including prisoners.<sup>64</sup>

Those with low levels of intellectual functioning may have difficulties within the prison in meeting their daily basic needs. They may be excluded from offending behaviour programmes, or fail to demonstrate sufficient progress if they do participate. Prisoners with a screening IQ score in the Extremely Low range may experience difficulties in progressing through the prison system.

In addition to areas of need related more directly to mental health, it is also vital to consider a range of needs related to prisoners' daily life and welfare. The separation of agencies and departments within prison settings – as elsewhere – is unlikely to facilitate the recognition of the impact of these needs on mental health, or recognition of the implications of mental health problems for prisoners' ability to access services. Unmet needs in areas such as work and basic education may be missed opportunities for the development of skills which contribute to reducing the risk of future reoffending. Unmet needs in areas such as the risk of harm to self (and others) suggests that in the area of safety and suicide reduction, there is still work to be done.

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<sup>64</sup> South East Regional Public Health Group (2007) Information Series 8: Promoting well-being for people at risk of mental health problems, <http://www.swpho.nhs.uk/resource/item.aspx?RID=29114>

### ***5.10 Palliative Care and End of Life Care***

There is little evidence re the prevalence or need for palliative or end of life care within the prison environment however a study by Lancaster University concluded that compared to the general population the needs of prisoners for palliative or end of life care is small.<sup>65</sup>

However as the number of older prisoners within the prison population increases and the likelihood that this will result in an increase in long term conditions it is likely that the number of prisoners requiring palliative care could increase in the future.

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<sup>65</sup> Turner M, Payne S, Kidd H, Barbarachild Z. Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire

## 6. COMPARATIVE NEEDS ASSESSMENT

| No.   | Indicators for 2011   | Prisons |                 |       |         |        |
|-------|---|---------|-----------------|-------|---------|--------|
|       |   | Kirkham | Lancaster Farms | Garth | Preston | Wymott |
| 1.1   | Patient Safety  |         |                 |       |         |        |
| 1.2   | Healthcare Environment  |         |                 |       |         |        |
| 1.3   | Medicines Management  |         |                 |       |         |        |
| 1.4   | Chronic Disease and Long Term Conditions Care (incorporating no GMS Quality and Outcomes Framework) |         |                 |       |         |        |
| 1.5   | Discharge Planning  |         |                 |       |         |        |
| 1.6   | Clinical Governance   |         |                 |       |         |        |
| 1.7   | Corporate Governance  |         |                 |       |         |        |
| 1.8   | Information Governance  |         |                 |       |         |        |
| 1.9   | Financial Governance  |         |                 |       |         |        |
| 1.10  | Workforce   |         |                 |       |         |        |
| 1.11  | Equality & Human Rights   |         |                 |       |         |        |
| 1.12  | Service User Involvement  |         |                 |       |         |        |
| 1.13  | Health Needs Assessment   |         |                 |       |         |        |
| 1.14  | Access & Waiting Times  |         |                 |       |         |        |
| 1.15  | Prison Dentistry  |         |                 |       |         |        |
| 1.16  | Substance Misuse Activities - IDTS  |         |                 |       |         |        |
| 1.17  | Alcohol Screening, Intervention and Support   |         |                 |       |         |        |
| 1.18  | Reception Screening and General Health Assessment   |         |                 |       |         |        |
| 1.19a | Services for Children & Young People (YOI only)   | N/A     | N/A             | N/A   | N/A     | N/A    |
| 1.19b | Services for Older Adults (Not YOI Estate)  |         | N/A             |       |         |        |
| 1.20  | Services for Adult Women  | N/A     | N/A             | N/A   | N/A     | N/A    |
| 1.21  | Primary Care Mental Health  |         |                 |       |         |        |
| 1.22  | Suicide Prevention  |         |                 |       |         |        |
| 1.23  | Care Programme Approach Audit   |         |                 |       |         |        |
| 1.24  | Access to Specialist Mental Health Services   |         |                 |       |         |        |
| 1.25  | Section 117 (Mental Health)   |         |                 |       |         |        |
| 1.26  | Mental Health Transfers   |         |                 |       |         |        |
| 1.27  | Services for People with Learning Disability  |         |                 |       |         |        |
| 1.28  | Hepatitis B Vaccination of Prisoners  |         |                 |       |         |        |
| 1.29  | Hepatitis C   |         |                 |       |         |        |
| 1.30  | Health Promotion Action Groups  |         |                 |       |         |        |
| 1.31  | Sexual Health   |         |                 |       |         |        |
| 1.32  | Communicable Disease Control  |         |                 |       |         |        |

## 6.1 ANALYSIS

Overall there has been a significant improvement in performance for all prisons from 2008/09 to 2010/11. Nevertheless there are some areas of concern that need addressing;

### **Kirkham**

#### **Amber**

- Chronic Disease and Long-Term Conditions Care
  - Much work has been done in Kirkham but the PCT continues to work with Kirkham to produce an action plan to manage chronic disease care delivery. Recording amber because clinics are in place and well established however, data is linked to electronic prescribing which is being implemented at present
- Learning disabilities
  - The prison has tried to obtain input from NACRO around LD but have had no further work on this. Looking to obtain consistent LD training across North Lancashire area, prisons to be included in this agenda. County MDO co-ordinator also needs to be involved. No formally commissioned service. Looking at community LD services to in-reach to the prisons. Existing links with community currently informal.
- Hep B vaccination
  - Immunisation Policy in place. Recent problem with Hepatitis B vaccination supply from Lloyds Pharmacy has now been addressed. This had prevented healthcare from providing vaccinations during this time. Average 70% coverage for the previous quarter. Quarter 1 April to June 2011 100% each month

#### **Red**

- Financial governance
  - Concerns raised regarding reinvestment of under spend into healthcare, to be discussed further by the Commissioners
- Prison dentistry
  - No hygienist however the dental nurse provides this service, health promotion literature available. 13 week wait currently for the dentist largely due to an increase in the population at Kirkham. Wait now reduced to 7 weeks and 5 days

## **Lancaster Farms**

### **Amber**

- Chronic Disease and Long-Term Conditions Care
  - QOF not yet in place on SystemOne but work ongoing to resolve this.
- Alcohol screening, intervention and support
  - No Alcohol Related Violence Course available. Governor agreed there are a full range of healthcare interventions available but no prison wide interventions, therefore rated Amber
- Mental health transfers
  - 3 patients assessed, 1 recently transferred 2 due to breach 12 week target.
- Learning disability
  - No Learning Disability service commissioned. Learning disability working group formed. Joint working with Community service. Service is developing.
- Hepatitis B vaccination of prisoners
  - Recent issue with Hepatitis B vaccination supply from Lloyds which has now been addressed, this prevented healthcare from providing vaccinations during this time. Catch up sessions now in place.
- Hepatitis C
  - Sexual Health clinic provide screening. Draft protocol. Harm minimisation information available. IDTS nurse development to provide screening in future.

### **Red**

- Financial governance
  - Concerns raised regarding reinvestment of under spend into healthcare, to be discussed further by the Commissioners.
- Primary care mental health
  - There still remains no formally commissioned service; work is being done informally currently.

## **Garth**

### **Amber**

- Corporate governance



- Workforce
- Health needs assessment
  - Although no formal needs assessment has been completed for a number of years, annual updates and data analysis has been used to inform work within the prisons.
- Alcohol screening, intervention and support
- Learning disabilities

## **Red**

- Financial governance
- Hepatitis B vaccination of prisoners

## **Preston**

### **Amber**

- Corporate governance
- Workforce
- Health needs assessment
  - Although no formal needs assessment has been completed for a number of years, annual updates and data analysis has been used to inform work within the prisons.
- Alcohol screening, intervention and support
- Services for older adults
- Learning disabilities
- Health promotion action groups

## **Red**

- Financial governance
- Hepatitis B vaccination of prisoners

## **Wymott**

### **Amber**

- Corporate governance
- Workforce
- Health needs assessment

- Although no formal needs assessment has been completed for a number of years, annual updates and data analysis has been used to inform work within the prisons.
- Alcohol screening, intervention and support
- Learning disabilities

#### Red

- Financial governance
- Hepatitis B vaccination of prisoners
- Sexual health

## 6.2 HEALTH CARE SERVICES

Expected outcomes:

Prisoners should be cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive in the community.

### 6.2.1 Effectiveness of services and interventions

Prisoners have the same right to health care as everyone else and prison partnership boards have a responsibility to ensure that prisoners receive proper health care and that prison conditions promote the well-being of both prisoners and prison staff.<sup>66</sup>

There are several international standards defining the quality of health care that should be provided to prisoners. The United Nations (1990) Basic Principles for the Treatment of Prisoners specify how the entitlement of prisoners to the highest attainable standard of health care should be delivered. Principle 9 states - ***“Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”***<sup>67</sup>

A review by the Regional Commissioned research Committee in 2002 found that the evidence base for effective models of care in the prison setting is weak however it did

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<sup>66</sup> World Health organisation. Health in prisons A WHO guide to the essentials in prison health, 2007

<sup>67</sup> United Nations (1990). Basic Principles for the Treatment of Prisoners. Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990. New York, United Nations

identify key elements of effective health and wellbeing care in the prison setting which were:<sup>68</sup>

- Health promotion as a unifying concept for health care in prisons incorporating health needs assessment
- Health screening on arrival in the prison system incorporating standardised protocols and validated instrument with an emphasis on mental health
- Partnership between prison services and the NHS
- Telemedicine as one mode of delivering health care in prisons
- Education of prison staff, including health care staff about the health needs of prisoners
- Developing a model of prison health care which looks beyond the prison environment to the communities which the prison serves

The Prison Health Research Network was set up in 2004 (now the Offender Health Research Network). This network supports the building of an evidence base and aims:

- to develop a multi-disciplinary, multi-agency network focused on offender health care innovation, evaluation and knowledge dissemination
- staff capability building through training opportunities and active involvement in health care research
- to work toward developing the frequency and quality of user/carer involvement in offender health care provision and research
- to develop a "pathway to research", outlining the processes required to successfully undertake research in the Criminal Justice System, including information on funding, research ethics and governance, and practical information about conducting research in such a unique environment

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<sup>68</sup> Regional Commissioned Research Committee, Health Care and Change Management in the Context of Prisons. April 2002

### *6.2.2 Literature review of effective services, interventions, and guidelines.*

A review of the literature and available best practice guidelines is included here to support future service reviews.

### *6.2.3 Physical health*

#### **Health promotion**

As the prison service, in partnership with the NHS, has a responsibility to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the NHS. Prisoners should be provided with health education, patient education, prevention and other health promotion interventions within the general context of PSO3200 and Health Promoting Prisons: a shared approach.<sup>69 70</sup>

The aim of a health promoting prison is to:

- 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.

#### **Health Trainers**

Many Prisons are taking part in a national initiative to improve positive physical and consequently mental health outcomes. The project known as Health Trainers Project is a national peer education project, operating across England. By training individual prisoners in the prison community to sign-post their peers towards health services, it is hoped that individuals in the prison community will have better access to healthy living information and preventions which may help to improve their health. Individuals trained as health trainers in prison may also be able to find work in the community as a health trainer upon release.

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<sup>69</sup> [http://pso.hmprisonservice.gov.uk/PSO\\_3200\\_health\\_promotion.doc](http://pso.hmprisonservice.gov.uk/PSO_3200_health_promotion.doc)

<sup>70</sup> Dept. health 2002 Health Promoting Prisons: a shared approach. DH London

## **The Expert Patients Programme (EPP)**

The EPP is a self-management programme for people who are living with a chronic (long-term) condition. The aim is to support people who have a chronic condition by:

- increasing their confidence
- improving their quality of life
- helping them manage their condition more effectively

### **6.2.3.1 Long term Conditions**

#### **Epilepsy**

Recent research shows that fewer prisoners than expected achieve seizure control with collaboration with specialist epilepsy services being poor and significant discrepancies between the healthcare provision in prison and the NICE epilepsy guidelines.<sup>71</sup>

NICE Guideline on Epilepsy provides a good practice base from which to deliver equivalence of service for all NHS users, including prisoners.<sup>72</sup>

#### **Asthma**

Asthma is a potentially life threatening condition and a number of widely accepted guidelines are available on the management of asthma however there are no specific guidelines for asthma care in prisons but the British Thoracic Society/Sign guidelines, for general population, are applicable to a prison setting.<sup>73</sup>

NICE produce specific guidance on pharmacotherapy for the management of chronic asthma TA138 and TA 139<sup>74 75</sup>

The Outcomes strategy for COPD and Asthma has recently been published by the Department of Health.

#### **COPD**

NICE guidance CG101 for the management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update) provides evidence based guidelines for effective treatment.<sup>76</sup>

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<sup>71</sup> Tittensor P, Collins J, Grünewald RA, Reuber, M (2008). Audit of healthcare provision for UK prisoners with suspected epilepsy . Seizure. 2008 Jan;17(1):69-75. Epub 2007 Aug 27

<sup>72</sup> National Institute of Health and Clinical Excellence guideline: CG20 Epilepsy in adults and children: NICE guideline. October 2004

<sup>73</sup> BTS/SIGN Guideline for the Management of Asthma, 2011

<sup>74</sup> <http://guidance.nice.org.uk/TA138>

<sup>75</sup> <http://guidance.nice.org.uk/TA133>

The Department of Health has recently published an Outcomes strategy for COPD. It aims to set out best practice guidance to achieve health outcomes and reduce health inequalities in Chronic Obstructive Pulmonary Disease (COPD) and asthma. Therefore any recommendations for the provision of COPD identification and treatment will be appropriate for provision of care in the prisons.<sup>77</sup>

## **Diabetes**

Imprisonment can ensure screening for diabetic complications and reassessment of treatment regimens and diabetic control can be maintained through the dietary regime and absence of alcohol in prisons.<sup>78</sup>

The standard of care should be equivalent to those in the general population. The PCT-commissioned services in prison (including commissioned social care services) should be working towards the delivery of diabetes care being at the same standard of process and outcomes as is required by the National Service Frameworks for diabetes. NICE Guidance and the National Service Frameworks provide a good practice base from which to deliver equivalence of service for all NHS users, including prisoners.<sup>79 80 81</sup>

## **CVD**

National Service Frameworks on CHD and long-term conditions<sup>82</sup> and NICE guidelines on chronic heart failure, hypertension, types 1 and 2 diabetes<sup>83</sup> provide a good practice base from which to deliver equivalence of service for all NHS users, including prisoners. There are also NICE guidelines related to the risk factors such as hypertension and blood cholesterol that are relevant for the prevention and management of CVD.

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<sup>76</sup> NICE guidance CG101 Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update). Accessed at: <http://www.nice.org.uk/CG101>

<sup>77</sup> Department Health 2011 An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma DH London

<sup>78</sup> MacFarlane IA. (1996). The development of healthcare services for diabetic prisoners. [Review] Postgraduate Medical Journal. 72(846):214-7

<sup>79</sup> Department of Health (2001). National service framework for diabetes: standards, DoH, 2001

<sup>80</sup> National Institute of Health and Clinical Excellence. CG87 Type 2 diabetes - newer agents (a partial update of CG66): short guideline 18 June 2009

<sup>81</sup> Type 2 diabetes: the management of type 2 diabetes (update). NICE clinical guideline 66 (2008). Available from [www.nice.org.uk/CG066](http://www.nice.org.uk/CG066)

<sup>82</sup> Department of Health (2000). National service framework for coronary heart disease - modern standards and service models

<sup>83</sup> National Institute of Health and Clinical Excellence: guidelines on chronic heart failure, hypertension, types 1 and 2 diabetes accessed at <http://guidance.nice.org.uk/Topic/Cardiovascular>

## Hypertension

Hypertension: management of hypertension in adults in primary care. NICE clinical guideline 34 (2006)<sup>84</sup>

The NHS Health Check is also part of a new national scheme to help prevent the onset of non communicable health problems heart disease, stroke, type 2 diabetes and kidney disease. Everyone between the ages of 40 and 74 who has not been diagnosed with the conditions mentioned will be invited for a check once every five years.

## Serum Cholesterol

Blood cholesterol can be reduced by dietary change, physical activity and drugs. Nice guidance addresses the identification of those at high risk, and the modification of lipids in these people and people with established CVD. Treatment should be aimed at reducing overall risk and based on an approach that addresses all risk factors to achieve most benefit. This is because the effect of modifying several risk factors is multiplicative.<sup>85,86,87,88</sup>

### 6.2.3.2 Cancer

There are NICE clinical guidelines on referral for suspected cancer which provide guidance to primary care in making decisions about when to refer people to specialists when they present with symptoms that could be caused by cancer.<sup>89</sup>

Age and gender appropriate national screening programmes such as bowel screening are available for those over the age of 65. The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 69.<sup>90</sup>

NICE guidance CG 58 sets out diagnosis and treatment guidelines for prostate cancer and the Prostate cancer risk management programme provides the evidence base for PSA testing in primary care.<sup>91 92</sup>

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<sup>84</sup> [www.nice.org.uk/CG034](http://www.nice.org.uk/CG034)

<sup>85</sup> [www.nice.org.uk/CG67](http://www.nice.org.uk/CG67)

<sup>86</sup> [www.nice.org.uk/CG071](http://www.nice.org.uk/CG071)

<sup>87</sup> [www.nice.org.uk/TA132](http://www.nice.org.uk/TA132)

<sup>88</sup> [www.nice.org.uk/TA094](http://www.nice.org.uk/TA094)

<sup>89</sup> <http://guidance.nice.org.uk/CG27>

<sup>90</sup> <http://www.cancerscreening.nhs.uk/bowel/about-bowel-cancer-screening.html#why-screen>

<sup>91</sup> <http://guidance.nice.org.uk/CG58>

<sup>92</sup> Burford DC, Kirby M, Austoker J. *Prostate Cancer Risk Management Programme information for primary care; PSA testing in asymptomatic men. Evidence document.* NHS Cancer Screening Programmes, 2010. Available at: <http://www.cancerscreening.nhs.uk/prostate/pcrmp-guide-2.html>

## 6.2.4 Communicable Diseases

The Health Protection Agency provides guidance for healthcare workers and other staff who work in prisons and places of detention. The manual provides advice on specific infections and dealing with outbreaks, key points on immunisation and vaccination and guidance on infection prevention and control within custodial settings.<sup>93</sup>

### Blood Borne Viruses

The prison setting provides an excellent opportunity to screen for and treat sexually transmitted infections, HIV, Hepatitis C virus, chronic hepatitis B virus infections and tuberculosis and to develop effective prevention programmes.<sup>94</sup>

Screening for HCV has been reported to be an effective intervention in managing the disease.<sup>95</sup> In addition, the current UK guidance on immunisations recommends vaccinations against Hepatitis B for all new prisoners entering prisons in the UK.<sup>96</sup>

Prison Health Performance and Quality Indicators, in use since 2007/08, include data on the achievement of targets for hepatitis B vaccination and hepatitis C screening in prisons in England.<sup>97</sup>

Needle and syringe programmes and opioid substitution therapies have proven effective at reducing HIV risk behaviours and HCV in a wide range of prison environments, without resulting in negative consequences for the health of prison staff or prisoners.<sup>98 99</sup>

According to WHO, measures to prevent the transmission of infectious diseases among drug users include:<sup>100</sup>

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<sup>93</sup>Health protection Agency 2011 Prevention of infection and communicable disease control in prisons and places of detention accessed at [http://www.hpa.org.uk/webc/HPAwebFile/HPAweb\\_C/1309970446427](http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1309970446427)

<sup>94</sup> Flanigan, TP., Zaller, N., Taylor, L., Beckwith, C., Kuester, L., Rich, J & Carpenter, C (2009). HIV and Infectious Disease Care in Jails and Prisons: Breaking Down the Walls with the Help of Academic Medicine. *Trans Am Clin Climatol Assoc.* 120: 73–83

<sup>95</sup> Health protection agency. *Infection Inside The Prison Infectious Disease Quarterly* March 2011 Volume 7, Issue 1

<sup>96</sup> Department of Health (2006), *Immunisation against infectious disease: The Green Book* (DH 2006) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917)

<sup>97</sup> Department of Health. *Prison health performance indicators* (2007 edition) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079860](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079860)

<sup>98</sup> Jürgens, R., Ball, A., Verster, A (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. *The Lancet Infectious Diseases*, Volume 9, Issue 1, Pages 57 – 66

<sup>99</sup> Wright, NMJ & Tompkins, C (2006). A review of the evidence for the effectiveness of primary prevention interventions for Hepatitis C among injecting drug users. *Harm Reduction Journal* 2006, 3:27

<sup>100</sup> World Health organisation. *Health in prisons A WHO guide to the essentials in prison health*, 2007



- communicating face to face: counselling, personal assistance, assistance from and
- integration of outside AIDS-help agencies and safer-use training for drug users;
- providing leaflets;
- implementing vaccination programmes against hepatitis A and B and tuberculosis;
- making condoms available;
- making bleach or other decontaminants available; and
- making sterile injecting equipment available.

## **TB**

For tuberculosis, in the absence of robust research on effective interventions, NICE guideline on tuberculosis provides recommendations on tuberculosis management in prison setting.<sup>101</sup> The Chief Medical Officer action plan Stopping tuberculosis in England identifies prisoners as an important part of the TB control strategy.<sup>102</sup> It is important to raise awareness of signs and symptoms in prisoners, prison staff and healthcare workers working in prisons and remand centres and the HPA provides a variety of resources to support this.

## **STIs**

In the recommended standards for sexual health services, there are a number of key evidence-based interventions which are applicable to sexual health services within prisons. These include the provision of:

- High quality sexual history taking and risk assessment which will enable people to receive appropriately targeted advice and information on the prevention of STIs and HIV.
- Comprehensive and appropriate assessment of prisoners sexual health needs including STI and HIV risks and need for screening.
- Education and support to minimise the risk of transmission or further acquisition of infection, or of negative psychosocial outcomes associated with STIs.
- Shared decision-making between professionals and individual service users which can result in better health outcomes.<sup>103</sup>

<sup>101</sup> National Institute of Health and Clinical Excellence. Clinical Guideline 117. Tuberculosis Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. clinical guideline (March 2011)

<sup>102</sup> [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4090417](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090417)

<sup>103</sup> Department of Health. Recommended standards for sexual health services 16 March 2005

NICE Public health guidance PH3 Prevention of sexually transmitted infections and under 18 conceptions sets out the requirements for the assessment, provision of advise and contact tracing.<sup>104</sup>

The Health Protection Agency also provide recommendations regarding access to sexual health services in prisons including access to condoms and lubricant, genitourinary medicine services and the national Chlamydia screening programme.

<sup>105</sup>

### **Gastro-intestinal disease**

The Health Protection Agency provides specific guidance for managing gastro intestinal infection outbreaks in prisons<sup>106</sup>

### **Influenza**

Guidance on responding to cases or outbreaks of Seasonal Flu in prisons has been produced jointly by Offender Health and the HPA. The document provides clear guidance on how to manage isolated cases/outbreaks of seasonal influenza in prisons and other places of detention.<sup>107</sup>

### **Immunisation and vaccination**

UK guidelines on immunisation against infectious diseases (*The Green Book*) should be the primary source of information on all issues in relation to vaccinations.<sup>108</sup> The Health Protection Agency has also produced guidelines on vaccination requirements of prisoners<sup>109</sup> Advice on vaccination for an HIV-infected individual is available from the British HIV Association.<sup>110</sup>

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<sup>104</sup> <http://www.nice.org.uk/guidance/PH3>

<sup>105</sup> Department Health 2011 Health Protection in Prisons: A Report to Offender Health from the Health Protection Agency Annual Report 2009-10.

<sup>106</sup> Health protection Agency 2011 Prevention of infection and communicable disease control in prisons and places of detention accessed at [http://www.hpa.org.uk/webc/HPAwebFile/HPAweb\\_C/1309970446427](http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1309970446427)

<sup>107</sup> Health Protection Agency 2010 Guidance on responding to cases or outbreaks of Seasonal Flu 2010/2011 in prisons and other closed institutions within the criminal justice system in England. <http://www.hpa.org.uk/servlet/Satellite?c=Page&childpagename=HPAweb%2FPage%2FHPAwebAutoListName&cid=1153999752025&p=1153999752025&pagename=HPAwebWrapper&searchmode=simple&searchterm=influenza+in+prisons>

<sup>108</sup> Department Health 2006 updated version The Green Book available at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917)

<sup>109</sup> <http://www.hpa.org.uk>

<sup>110</sup> <http://www.bhiva.org/Home.aspx>

### 6.2.5 Special Senses and Disability

HMPS disability strategy sets out a number of initiatives to create and promote a prison service which fully reflects the requirements of the Disability Discrimination Act 1995 and is free of discrimination on the grounds of disability.<sup>111</sup>

The Bradley Report (2009) recommends a unified approach from all relevant agencies to ensure the early identification of offenders with learning disabilities and to help to enable appropriate diversion and sentencing.<sup>112</sup>

In addition, the DH has produced a handbook, for professionals in criminal justice system, which has practical introduction to learning disabilities as well as sign-posting to resources and organisations that can provide specialist support and advice.<sup>113</sup>

### 6.2.6 Mental Health

Lord Bradley's recommendations for improving mental health outcomes for offenders aimed to ensure offenders have similar access to mental health services as the rest of the population. Additionally early identification and intervention is a priority in the criminal justice system. The report also proposed rolling out a national liaison and diversion service at police stations and at courts by 2014.

### 6.2.7 Substance misuse

Substance misuse is a major problem in the prison population but, whilst there is a large body of evidence for community-based drug treatments, there has been far less research in prison settings.

The National Offender Management Service has a strategy relating to problematic drug users in correctional services.<sup>114</sup>

HM Prison Service have in place drug and alcohol strategies<sup>115</sup>, as well as a good practice guide for alcohol treatment and interventions.<sup>116</sup>

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<sup>111</sup> Disability Strategy (HMPS 2004) [http://www.hmprisonservice.gov.uk/assets/documents/10000510Disability\\_Strategy\\_Document.doc](http://www.hmprisonservice.gov.uk/assets/documents/10000510Disability_Strategy_Document.doc)

<sup>112</sup> The Bradley Report, 2009. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

<sup>113</sup> Department of Health. Positive Practice Positive Outcomes A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Disabilities 2011 EDITION.  
<http://www.parliament.uk/deposits/depositedpapers/2011/DEP2011-0384.pdf>

<sup>114</sup> NOMS (2005) Strategy for the management and treatment of problematic drug users within the correctional services. NOMS; London

In addition, the cross-Government document 'Safe Sensible Social' updating the national alcohol strategy, contains specific recommendations for offender populations.<sup>117</sup>

A DH guidance into clinical management of drug dependence in the adult prison setting, sets out how prison-based drug and alcohol services for adults should develop.<sup>118</sup> The principle of the guidance is withdrawal prescribing, informed by screening and assessment.

The evidence for treating dependence on substances other than opioids shows very limited success to date in community settings, and is non-existent in offender settings. Evidence from community settings show that psychosocial interventions are effective for opioid dependence only when delivered in combination with pharmacological detoxification treatment.<sup>119</sup> In addition the interaction between approaches is of particular importance to prison populations where the aim is to keep prisoners drug-free on release. An integrated approach to drug dependence is widely recognised as the most effective intervention method.

NICE has produced two guidelines on drug misuse – 'Drug misuse: psychosocial interventions' (NICE clinical guideline 51) and 'Drug misuse: opioid detoxification' (NICE clinical guideline 52). They cover:

- the support and treatment people can expect to be offered if they have a problem with or are dependent on opioids, stimulants or cannabis
- how families and carers may be able to support a person with a drug problem and get help for themselves.

NICE clinical guideline 52 makes recommendations for the treatment of people who are undergoing detoxification for opioid dependence arising from the misuse of illicit drugs, i.e. Opioid detoxification should not be routinely offered to people: with a medical condition needing urgent treatment: in police custody, or serving a short prison sentence or a short period of remand; consideration should be given to treating opioid withdrawal symptoms with opioid agonist medication: who have

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<sup>115</sup> HM Prison Service. 2006. Continuity of healthcare for prisoners: Prison Service Order 3050. London: HM Prison Service

<sup>116</sup> HM Prison Service. 2004. Reception: Prison Service Order 0500. London: HM Prison Service

<sup>117</sup> Department of Health (2007). Safe. Sensible. Social. The next steps in the National Alcohol Strategy

<sup>118</sup> Department of Health (2006). Clinical management of drug dependence in the adult prison setting. London: Department of Health

<sup>119</sup> Amato L, Minozzi S, Davoli M, Vecchi S, Ferri M & Mayet S (2004) Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. Cochrane Database of Systematic Reviews 2004, 4 CD005031

presented to an acute or emergency setting; the primary emergency problem should be addressed and opioid withdrawal symptoms treated, with referral to further drug services as appropriate.<sup>120</sup>

The Department of Health has also provided guidance on the pharmacological management of substance misuse among young people in secure environments.<sup>121</sup> This guidance document describes good practice on the best ways to manage a clinically complex condition.

A report by Professor Lord Patel of Bradford OBE, chair of the independent Prison Drug Treatment Strategy Review Group has been produced on drug treatment and interventions in prison and has been submitted to Ministers in the Home Office, the Ministry of Justice and the Department of Health in response to the drug strategy consultation. The report focuses on drug treatment and interventions for people in prison, people moving between prisons and the continuity of care for people on release from prison. The report outlines the evidence gathered and work carried out by the Review Group and summarises their conclusions and recommendations.<sup>122</sup>

Prison service instruction PSI 45/2010 sets out the mandatory requirements for prisons to support and facilitate the delivery of the integrated drug treatment system (IDTS).<sup>123</sup> IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:

- early custody;
- improving the integration between clinical and CARAT Services; and
- reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Further updates from the National treatment Agency have been published following the implementation of the Integrated Drug Treatment System (IDTS) concerning use of pharmacological products and recording of treatment regimes.<sup>124</sup>

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<sup>120</sup> <http://guidance.nice.org.uk/CG52>

<sup>121</sup> Department Health 2009 Guidance on the pharmacological management of substance misuse among young people in secure environments . at:  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_106433](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106433)

<sup>122</sup> The Patel report: Reducing drug-related crime and rehabilitating offenders at  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_119851](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119851)

<sup>123</sup> [http://www.justice.gov.uk/downloads/guidance/prison-probation-and-rehabilitation/psipso/psi\\_2010\\_45\\_IDTS.doc](http://www.justice.gov.uk/downloads/guidance/prison-probation-and-rehabilitation/psipso/psi_2010_45_IDTS.doc)

<sup>124</sup> [http://www.nta.nhs.uk/uploads/updated\\_guidance\\_for\\_prisons\\_march10.pdf](http://www.nta.nhs.uk/uploads/updated_guidance_for_prisons_march10.pdf)

### 6.2.8 Alcohol misuse

For alcohol dependence, the guidance states that prisoners should be assessed for alcohol withdrawal at reception into prison, and detoxification, if required, should be with chlordiazepoxide and thiamine from the first night of custody. Treatment should be in line with HM Prison Service guidance.<sup>125</sup>

A substantial prison health needs assessment—alcohol has recently been undertaken in Scotland.<sup>126</sup> The HNA rapid review of the evidence found that:

- Three screening tools were identified as having good reliability with offending populations, although no single screening tool was identified as superior and more than one screening tool may be required for this diverse population. Timing of screening may be an issue.
- Current evidence is limited for most interventions in prison settings.
- Many studies conflate alcohol and drugs making it difficult to identify specific alcohol-related outcomes.
- There is also a particular lack of published research from the UK, although several relevant studies are currently in progress.
- Whilst there is evidence of the effectiveness of therapeutic communities this is only the case for people with alcohol use *in addition* to drug misuse, and studies report that they are costly and time intensive.
- Alcohol brief interventions (ABIs) have the highest quality evidence base but effectiveness in this setting is still to be established.
- There is some evidence that addiction interventions have an economic benefit through the reduction of reoffending.
- Overall, there is a need for more research in the area of effectiveness of alcohol interventions in prison populations, in particular in identifying screening tools that work with this population.

A National Treatment Agency for Substance Misuse review places a great emphasis on the use of psychosocial interventions, including brief and extended treatments, for

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<sup>125</sup> HM Prison Service. 2004. *Reception: Prison Service Order 0500*. London: HM Prison Service

<sup>126</sup> Parks et al. 2010 Prison Health Needs Assessment for alcohol problems. NHS Health Scotland. Accessed at: <http://www.ohrn.nhs.uk/resource/policy/PrisonHealthNeedsAssessmentAlcohol.pdf>

alcohol misuse, although the dearth of evidence base into the effectiveness of these interventions in a prison setting is acknowledged by the NTA review.<sup>127</sup>

There are a range of NICE guidance and quality documents to support the commissioning of alcohol services.<sup>128,129,130,131,132</sup>

- Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults.
- NICE quality standard. Alcohol dependence and harmful alcohol use
- NICE clinical guideline 115. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
- NICE clinical guideline 100. Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications
- NICE public health guidance 24. Alcohol-use disorders: preventing the development of hazardous and harmful drinking

### 6.2.9 Smoking

The Department of Health provides guidance and recommendations for the provision of evidence based specialist Stop Smoking services. Although there is not enough evidence to suggest the best type of intervention specifically for prison settings it is appropriate to provide those offered to the general population.<sup>133</sup> Guidance sets out the basic quality principles for stop smoking intervention:

- Offer a menu of evidence based support options
- Ensure that the intervention is delivered by a trained stop smoking adviser
- Allow access to NICE approved pharmacotherapy
- Use CO validation in at least 85% of cases
- Provide support for the duration of the treatment.

There are a range of NICE guidance and quality documents to support the commissioning of tobacco services.

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<sup>127</sup> [http://www.nta.nhs.uk/uploads/guidance\\_for\\_the\\_pharmacological\\_management\\_of\\_substance\\_misuse\\_among\\_young\\_people\\_in\\_secure\\_environments1009.pdf](http://www.nta.nhs.uk/uploads/guidance_for_the_pharmacological_management_of_substance_misuse_among_young_people_in_secure_environments1009.pdf)

<sup>128</sup> <http://www.nice.org.uk/usingguidance/commissioningguides/alcoholservices/AlcoholServices.jsp>

<sup>129</sup> <http://www.nice.org.uk/guidance/qualitystandards/alcoholdependence/home.jsp>

<sup>130</sup> <http://www.nice.org.uk/cg115>

<sup>131</sup> <http://www.nice.org.uk/cg100>

<sup>132</sup> <http://www.nice.org.uk/ph24>

<sup>133</sup> Department Health 2011 Local Stop Smoking Services Service delivery and monitoring guidance 2011/12 London

NICE guidance:

- Public Health Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health intervention guidance 1 (2006)<sup>134</sup>.
- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007).<sup>135</sup>
- Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10 (2008).<sup>136</sup>

### 6.2.9 Obesity

Although there are no Public Service Agreements related to prisoner diet and exercise the National Audit office undertook a review of prisoner diets and exercise in 2006. This documents sets out a series of recommendations to ensure that prisoners are able to access appropriate diet and exercise.<sup>137</sup>

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.

Nice guidance:

- CG43 Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43 (2006).<sup>138</sup>
- NICE public health intervention guidance 2 (2006).<sup>139</sup>

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<sup>134</sup> [www.nice.org.uk/PHI001](http://www.nice.org.uk/PHI001)

<sup>135</sup> [www.nice.org.uk/TA123](http://www.nice.org.uk/TA123)

<sup>136</sup> [www.nice.org.uk/PH010](http://www.nice.org.uk/PH010)

<sup>137</sup> **Serving Time: Prisoner Diet and Exercise**

[http://www.nao.org.uk/publications/0506/prisoner\\_diet\\_and\\_exercise.aspx#fan4\\_back](http://www.nao.org.uk/publications/0506/prisoner_diet_and_exercise.aspx#fan4_back)

<sup>138</sup> [www.nice.org.uk/CG043](http://www.nice.org.uk/CG043)

<sup>139</sup> [www.nice.org.uk/PHI002](http://www.nice.org.uk/PHI002)



### 6.2.11 Dental

The Strategy for Modernising Dental Services for Prisoners in England identifies three key access standards:

- Emergency care, for example severe facial trauma and severe bleeding, may require access to an A&E department in line with local healthcare provision and subject to local prison security policies.
- Urgent care for dental pain and minor trauma will require access to a dentist within 24 hours. Where this cannot be achieved, an appropriate practitioner will see the patient within 24 hours to make an assessment as to the appropriate course of action.
- Appointments for routine care will not normally exceed six weeks from the time of asking.<sup>140</sup>

Following the modernising prison dental health strategy, a number of examples of good practice initiatives are identified in the reforming prison dental services in England<sup>141</sup>

- Health needs assessment - needs assessment of new prisoners at the point of admission and use this to prioritise dental treatment and access
- Oral health promotion and health improvement - establishing or extending oral health promotion services
- Increasing access to treatment – e.g., Prioritising patients using triage systems
- Continuity and follow up care – e.g., electronic records for patients and building relationships with local dentists

### 6.2.12 Palliative and End Life

A recent evaluation by Lancaster University in 2009 - Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire makes some recommendations around policy, practice, training and research.<sup>142</sup>

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<sup>140</sup> Strategy for Modernising Dental Services for Prisoners in England 2003health/prison\_dental\_reportWEB.pdf

<sup>141</sup> OPM. Reforming prison dental services in England – A guide to good practice, Sarah Harvey, Beth Anderson, Stefan Cantore, Ewan King and Farooq Malik. August 2005. [www.opm.co.uk/resources/48/download](http://www.opm.co.uk/resources/48/download)

<sup>142</sup> Turner M, Payne S, Kidd H, Barbarachild Z. Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire

The HM Inspectorate of Prison's report, 'No problems – Old and Quiet' (2005), makes reference to the state of palliative care in prisons in the UK.<sup>143</sup> It mentions that all prison healthcare centres are required to have a policy for palliative care. 18 healthcare managers were interviewed for the report. Of these only 11 had a policy, five did not and two were unsure. Two of the prisons had good liaison with the local Macmillan Team or local hospice team. Frankland Prison was commended for its policy which included the Macmillan end of life care pathway. However this was an exception.

### **6.2.13 Medicine management**

The Prison Performance Indicators makes specific reference to medicine management within prisons and links to the key recommendations within A Pharmacy Service for Prisoners June 2003.<sup>144</sup>

Related policy documents that are relevant to improving medicines management services in their broadest sense include:

- Choosing health through pharmacy (DH 2005)
- A Vision for Pharmacy in the New NHS (DH 2003)
- Implementation of NICE Guidelines and Technology Appraisals in prisons
- Implementing the new Community Pharmacy Contractual Framework: Information for Primary Care Trusts (DH 2005 (draft))
- Quality and Outcomes Framework (DH (nGMS contract) updated January 2006): clinical and medication-related outcomes should apply to prisoners
- A Self Care Challenge: A Strategy for Pharmacists in England (Royal Pharmaceutical Society of Great Britain 2006)
- Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006)
- Medicine Matters: A guide to the mechanisms of the prescribing, supply and administration of medicines (DH 2006)
- Building a Safer NHS for Patients: Improving medication safety (DH 2004)
- Medicines Management: A resource to support implementation of the wider aspects of medicines management for the National Service Frameworks for Diabetes, Renal Services and Long-Term Conditions (DH 2004).

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<sup>143</sup> HM Inspectorate of Prisons. No problems – old and quiet': Older prisoners in England and Wales A thematic review by HM Chief Inspector of Prisons. September 2004  
<http://www.justice.gov.uk/inspectors/hmi-prisons/docs/hmp-thematic-older-04-rps.pdf>

<sup>144</sup> Department Health 2003 A Pharmacy Service for Prisoners DH London

There are recommendations around medication in possession which should be the default for prisoners and a recent evaluation of these procedures within prisons was undertaken by the National Institute of Health Research.<sup>145</sup>

## 6.3 INFRASTRUCTURE

### 6.3.1 Overview of Healthcare Services

Each of the prisons provide primary care services similar to that found in the community. Healthcare provision in the prisons falls into four categories:

- Healthcare screening on admission to the prison (used to identify immediate healthcare needs on an prisoner's reception to the prison).
- Healthcare services provided on site (includes primary care and community care (e.g. GP, dentist, optometrist) as well as some secondary care in-reach services (e.g. GUM services, mental health In-reach).
- In-patient facility - Preston and Lancaster Farms ( Note Lancaster Farms ward is due for closure later this year).
- Access to healthcare provided off the prison estates.

As far as possible, prison healthcare needs are met within the prison setting and delivered by either the prison healthcare team or by 'visiting' services. Where this is insufficient to meet the needs of an individual prisoner, arrangements are made for the prisoner to see an appropriate hospital specialist. (In Kirkham once prisoners have settled from movement around the system, greater emphasis is placed on getting all health problems sorted prior to release, hence the high secondary care referral rates at Kirkham.) Out-of-hours cover is provided through arrangements with the GP services and through 24 hour nursing services where available.

This HNA does not cover or discuss the in patient facilities or the bed watch and escorts as these are subject to separate review.

Access to the healthcare system in all prisons is via nurse triage. In Kirkham patients come to healthcare to be assessed by a nurse, in the Farms, the triage nurse visits the prison wings each morning, a process known as 'sick parade'.

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<sup>145</sup> An evaluation of in-possession medication procedures within prisons in England and Wales A report to the National Institute of Health Research August 2009

In Garth, Wymott and Preston, patients are able to consult an appropriate Health Care Professional within 24 hours and a GP within 48 hours of a self referral or referral by staff being made.

A description of the staff employed at the prisons, the frequency of visiting professionals attending the prisons and the clinics provided at the prisons is presented below. It should be noted that Table 27 describes the current staffing levels at the prisons at the time of writing this report, and does not reflect changing staffing levels due to staff turnover and recruitment of vacant posts or for the imminent closure of the ward at Lancaster Farms.

Note that the figures for Lancaster Farms and Kirkham relate to whole time equivalent whilst numbers for Preston, Garth and Wymott relate to actual number of staff so cannot be compared across the two areas.

**Table: 27 Human resources employed within the 5 Lancashire prisons for health care and health promotion.**

| Human resources: employed within the prison  | Kirkham |                | Lancaster Farms  |              |                | Preston             |          |             | Garth  |             | Wymott |             |
|--|---------|----------------|------------------|--------------|----------------|---------------------|----------|-------------|--------|-------------|--------|-------------|
|  | wte     | Employed by    | Wte Primary care | Wte Ward     | Employed by    | number Primary Care | Wte Ward | Employed by | number | Employed by | number | Employed by |
| <b>Health care professionals: nurses</b>     |         |                |                  |              |                |                     |          |             |        |             |        |             |
| Health Care Manager                          | 1       | NHSNL          | 1                |              | NHSNL          | 1                   |          |             | 1      |             | 1      |             |
| Senior Nurse                                 | 2       | NHSNL          | 1 vacant         | 2 (1RMN,1LD) | NHSNL          | 2                   |          |             | 2      |             | 3      |             |
| Registered general nurse (RGN)               | 4.3     | NHSNL          | 7.2              |              | NHSNL          | 16                  |          |             | 13.5   |             | 16.75  |             |
| Registered Mental Health Nurse (RMN)         | 1       | LCFT           | 0                | 5.4          | LCFT           | 4                   |          |             | 5      |             | 8      |             |
| Learning Disability Nurse                    | 0.7     | NHSNL          | 0.5              | 2            | NHSNL          |                     |          |             |        |             |        |             |
| IDTS Nurses                                  | 3       | Delphi Medical |                  | 2            | Delphi Medical |                     |          |             |        |             |        |             |
| Health Care Orderly                          |         |                |                  |              |                | 5                   |          |             |        |             |        |             |
| Healthcare Assistants/support worker         | 1.6     | NHSNL          | 0                | 7            | NHSNL          | 10                  |          |             | 1      |             | 1      |             |
| <b>Managerial &amp; administrative staff</b> |         |                |                  |              |                |                     |          |             |        |             |        |             |
| Office manager                               | 0.56    | NHSNL          | 1<br>2           |              | NHSNL          |                     |          |             |        |             |        |             |
| Administrative/secretarial support           | 1.96    | NHSNL          |                  |              | NHSNL          | 5                   |          |             | 4      |             | 4.5    |             |
| IDTS Support                                 | 1       | Delphi         | 1.5              |              | Delphi         |                     |          |             |        |             |        |             |

|   |   |                |  |  |                |   |  |  |   |  |   |  |
|---|---|----------------|--|--|----------------|---|--|--|---|--|---|--|
| Worker/Administrator  |   | <b>Medical</b> |  |  | <b>Medical</b> |   |  |  |   |  |   |  |
| housekeeper   |   |                |  |  |                | 1 |  |  | 1 |  | 1 |  |
| <b>Allied health professionals</b>                                  |   |                |  |  |                |   |  |  |   |  |   |  |
| Pharmacist  | 0 |                |  |  |                |   |  |  | 2 |  |   |  |
| Pharmacy Technician   |   |                |  |  |                | 2 |  |  | 3 |  |   |  |
| Pharmacy Assistant  |   |                |  |  |                |   |  |  | 1 |  | 2 |  |
| Physiotherapists  | 0 |                |  |  |                |   |  |  |   |  |   |  |
| Speech and Language therapists                                      | 0 |                |  |  |                |   |  |  |   |  |   |  |
| Occupational therapists   | 0 |                |  |  |                |   |  |  |   |  |   |  |
| <b>Prison Officers</b>  |   |                |  |  |                |   |  |  |   |  |   |  |
| With First Aid training   | 0 |                |  |  |                |   |  |  |   |  |   |  |
| With other health training (e.g., depression awareness)             | 0 |                |  |  |                |   |  |  |   |  |   |  |
| Health Care Officers  | 0 |                |  |  |                |   |  |  |   |  |   |  |
| CARAT   |   |                |  |  |                |   |  |  |   |  |   |  |
| <b>Voluntary sector and self help organisations e.g. Samaritans</b> |   |                |  |  |                |   |  |  |   |  |   |  |

**Table 28 Visiting Healthcare professionals available to the 5 Lancashire prisons.**

| <b>Human resources: sessions provided within prisons</b> | <b>Kirkham</b>                   | <b>Lancaster Farms</b> | <b>Preston</b>    | <b>Garth</b>         | <b>Wymott</b> |
|--|----------------------------------|------------------------|-------------------|----------------------|---------------|
| <b>Health Care Professionals: doctors and dentists</b>   |                                  |                        |                   |                      |               |
| General Practitioners                                    | 2.5hrs/day                       | 1.5hrs/day             | 3.5 shared across | Preston/Garth/Wymott |               |
| General Dental Practitioners                             | 3 sessions/week                  | 2 days/week            |                   |                      |               |
| Psychiatrists  | 1 session per fortnight          | 6 sessions/week        |                   |                      |               |
| Other medical specialists                                | Optician 1 session per fortnight | 1 session/month        |                   |                      |               |
| <b>Health care professionals : nurses</b>                |                                  |                        |                   |                      |               |
| Sexual health  | 0                                | 1 session/week         |                   |                      |               |
| <b>Allied health professionals</b>                       |                                  |                        |                   |                      |               |
| Clinical psychologists                                   |                                  |                        |                   |                      |               |
| Occupational therapists                                  |                                  |                        |                   |                      |               |
| Speech and language therapists                           |                                  |                        |                   |                      |               |
| Physiotherapists   |                                  |                        |                   |                      |               |
| Counsellors  |                                  |                        |                   |                      |               |
| Pharmacists  |                                  |                        |                   |                      |               |
| Podiatrists  | 2hrs/fortnight                   | when required          |                   |                      |               |
| Dental Nurse   | 3 sessions/week                  | 2 days/week            |                   |                      |               |
| Optometrist  | 2hrs/fortnight                   | 4 hours/month          |                   |                      |               |
| Specialist Stop Smoking Advisers                         | 4.5hours/week                    | 4.5hours/week          |                   |                      |               |

### **6.3.2 Mental health services**

There are three integrated Criminal Justice Mental Health Teams (CJMHT) provided by Lancashire Care NHS Foundation Trust (LCFT) within Lancashire. These integrated multi-disciplinary CJMHTs provide services at any point along the offender journey in their respective geographical areas and incorporate existing Criminal Justice Liaison Teams (CJLTs) and Mental Health In Reach Teams (MHITs) to prisons (in areas where these exist) as follows:

#### **North Lancashire CJMHT**

MHIT for HMPs Lancaster Farms, Kirkham and CJLTs for North Lancashire (incorporating Blackpool and Lancaster)

#### **Central Lancashire CJMHT**

MHIT for HMP's Wymott & Garth and MHIT for HMP Preston. Also, CJLT for Chorley/South Ribble & West Lancashire and CJLT for Preston.

#### **East Lancashire CJMHT**

East Lancashire CJLT (no prisons in this area). Mental Health Outreach Practitioners for Lancashire Constabulary Integrated Offender Management Unit (Pennine Division) based at Burnley Police Station.

The CJMHT services aim to interface between mental health services and criminal justice agencies to ensure offenders with mental health problems are diverted to appropriate treatment, either instead of or in addition to a criminal justice sanction.

Practitioners provide assessment, advice, liaison and consultation for individuals, criminal justice partner agencies, mental health services, primary care services and the wider local community as appropriate. Entry to the service is based on referral from partner agencies or self referral and operates Monday to Friday. The MDO Co-ordinator for Lancashire Criminal Justice, Health and Social Care will also oversee the development of the CJMHTs consistent with the principles of the Bradley Report (DOH 2009).

LCFT also provide a rolling training programme to prisons, police, custody staff and MAPPA chairs on mental health issues. There is scope for this to be expanded wider and run the training as multi-agency.



The Mental Health Treatment Requirement (MHTR) is one of 12 options available to sentencers when constructing a community sentence (either a Community Order or a Suspended Sentence Order). MHTRs can be given to an offender who has mental health problems that would benefit from treatment if treatment under the Mental Health Act is not required. If an offender gives their consent to receiving an MHTR, they will receive clinical mental health treatment for a specified period under supervision by probation. At least 40% of offenders on community sentences are thought to have a diagnosable mental health problem (Sainsbury Centre 2009a) yet there has been little uptake of the MHTR in Lancashire since its implementation in 2005. Local uptake of the MHTR is to be considered, and data on this would be valuable.

In addition to the wider offender population, LCFT also provide a forensic community mental health team (FCMHT). The FCMHT is a community based specialist mental health team providing care designed to support and supervise service users with a diagnosis of severe and enduring mental illness/personality disorder within the Low and Medium Secure Services provided at Guild Lodge, Preston. Secure Services provide multidisciplinary inpatient treatment for individuals, in the main from Lancashire who require medium and low secure mental health inpatient care.

A Criminal Justice, Health and Social Care Co-ordinator post was developed in principle by Lancashire Constabulary, Lancashire Care Foundation Trust and the NW Secure commissioning Team. The post was created and jointly funded in April 2009 by Lancashire PCTs initially as a 2 year secondment. The role was to support the development of robust systems for the assessment, access to treatment, care management and appropriate diversion of individuals with a mental health or learning disability need. The role balances its time between police and mental health services and has been particularly successful in focusing actions in relation to the Bradley report and co-ordinated training packages.

## **6.4 DESCRIPTION OF OTHER HEALTH SERVICES**

### **6.4.1 Opportunities for self-care**

Opportunities for self-care are limited within the prisons. Compared to people in the community, prisoners do not have the same access to informal care and advice from

friends and family and access to health literature, the internet and over the counter medication.

## 6.5 PRIMARY CARE SERVICES

### 6.5.1 Optical

#### **Kirkham and Lancaster Farms.**

Opticians are commissioned to deliver a standard of care to the prison population that is equivalent to that delivered to the community based practice population but suitable to a custodial environment, and to follow their existing practice governance, protocols and procedures.

#### Service Description

The statutory duty is to follow the regulations and statutes governing the profession's exercise of its role and to do so with reasonable care and skill.

When carrying out a sight test the practitioners are expected to bear in mind the particular circumstances of the patient and their history and symptoms when determining the extent of the sight test. The sight test should normally include:

- Ocular history and symptoms, including relevant general health and family ocular history
- Basic binocular vision assessment
- External ocular examination
- Intra-ocular examination through undilated pupil (this may be done by use of an ophthalmoscope or by other means)
- Field screening for patients judged at risk by the optometrist
- Tonometry for patients judged at risk by the optometrist
- Maintaining records that show the results of the sight test
- Issuing the prescription or statement
- Giving verbal advice
- Writing a referral letter, if required

A clinic is held at YOI Lancaster Farms on the fourth Tuesday of each month commencing at 2pm.

The clinic for HMP Kirkham is held on alternate Mondays commencing from 2pm.

### **HMP Preston, Garth and Wymott**

The Provider will ensure prisoners have access to podiatry and optical services. Access to these services will be via referral from a GP or other healthcare professional working within the department through a referral protocol.

Patients referred into either service should be seen within 6 weeks or earlier if clinical needs dictate.

### **6.5.2 GP Service**

#### **HMP Kirkham and Lancaster Farms**

Delphi Medical Limited provide the GP service at both YOI Lancaster Farms and HMP Kirkham. The details of the service provided at each establishment is as follow:

##### HMP Lancaster Farms - GP Sessions

There is provision of five 2 ½ hr clinic sessions daily, Monday to Friday, which provide an holistic approach and incorporate the GP led Integrated Drug Treatment Service. Telephone consultation and support outside of the clinic sessions is available from 8.00am to 6.30pm.

The GP session provides standard core services as per the PMS Contract and IDTS GP support. The aim of the holistic approach is to meet the Department of Health requirements that Drug Treatment within prison environments is equal to that available in the community (including ensuring patients being prescribed medication fully engage with all drug treatment services).

Treatment is provided through a care planning approach so joint working between all Health Care and Drug treatment providers is essential to the service.

There is a minimum requirement that GP's will have completed Royal College of General Practitioners Level 1 certification in substance misuse (A single day course). To further increase prescriber's knowledge of prison related substance use, there is a Secure Environments Module of RCGP Substance Misuse which is a 2 days course.

There is a GP with specialist substance misuse experience and Level 2 RCGP Substance Misuse certification as a medical lead to the IDTS service. This specialist is available to support General Practitioners, and provide supervision and clinical governance advice.

NLTPCT also actively supports GP's who wish to register for RCGP Level 2, registrations.

#### HMP Kirkham - GP Sessions

There are five 2 ½ hr clinic sessions Monday to Friday, including telephone consultation outside of the clinic sessions up to 6.30pm. The GP session provides standard core services as per the PMS Contract.

In addition to this, one 2 ½ hr clinic is held each week for the Integrated Drug Treatment Service.

#### HMP Preston, Garth and Wymott

##### *Integrated Primary Care service – core hours*

The Provider will ensure as a minimum that Primary Care Services are available at each of the three Prisons and open in accordance with the times set out in the table below.

|                    |                     |                      |                        |                       |                     |                                   |
|--------------------|---------------------|----------------------|------------------------|-----------------------|---------------------|-----------------------------------|
| <b>HMP Wymott</b>  | 8am - 8pm<br>Monday | 8am - 8pm<br>Tuesday | 8am - 8pm<br>Wednesday | 8am - 8pm<br>Thursday | 8am - 5pm<br>Friday | 8.30am - 5pm<br>Saturday & Sunday |
| <b>HMP Preston</b> | 8am - 8pm           | 8am - 8pm            | 8am - 8pm              | 8am - 8pm             | 8am - 5pm           | 8.30am - 5pm                      |
| <b>HMP Garth</b>   | 8am - 8pm           | 8am - 8pm            | 8am - 8pm              | 8am - 8pm             | 8am - 5pm           | 8.30am - 5pm                      |

Provided within these hours, the Provider will ensure that:

- Patients are able to consult an appropriate Health Care Professional within 24 hours and a GP within 48 hours of the referral being made. For clarity, the date when a referral is made and received by the healthcare department is the date that a prisoner completes a self-referral form or requests access to the healthcare department by any other mechanisms.
- Where clinically necessary a patient is able to access a healthcare practitioner, or GP if appropriate, on the same day as the referral being made.
- Patients referred into a nurse-led clinic, are seen as soon as possible but within a maximum of 18 weeks of the referral being initiated.
- Patients referred to the Optometry and Podiatry service are seen as soon as possible but within a maximum of 18 weeks of the referral being initiated.
- Patients referred into the primary mental health care service including counselling services are seen within 18 weeks or earlier if clinical needs dictate.
- Treatment for patients suffering from immediate and life threatening conditions (as determined by a clinically trained individual at the Provider acting reasonably) is commenced immediately and the emergency services / protocols implemented immediately as required.
- Health assessments of new prisoners, including the issuing of prescriptions, are undertaken on the same day as the patient's reception.
- A doctor or a registered nurse completes an initial segregation health screen within two hours of a prisoner being housed in the Segregation Units complying with regulations in PSO1700 (<http://pso.hmprisonservice.gov.uk/pso1700/default.htm>).

### 6.5.3 Pharmacy

#### HMP Kirkham and Lancaster Farms

The Pharmacy service is expected to provide a safe, efficient and cost effective pharmacy service, which complies with Statutory Requirements, Prison Rules and Standing Orders, and professional and ethical codes of practice. The service is governed by the Code of Ethics of the Royal Pharmaceutical Society of Great Britain and it is expected that the level of service is at least commensurate with that found in the NHS, working within prison operational constraints. It is expected to ensure that a comprehensive range of medicinal products is available for the prevention, diagnosis and treatment of clinical conditions.

| Prison                              | Cut Off Time         | Delivery Time                            |
|-------------------------------------|----------------------|--|
| HMP Kirkham<br>(2 deliveries daily) | 13.30hrs<br>16.00hrs | 15.30hrs<br>10.00hrs (the following day) |
| HMP Lancaster Farms                 | 12.30hrs             | 15.00hrs                                 |

#### Direct services:

- Sourcing of medicines and medical consumables
- Dispensing and delivery of prescription medicines and medical consumables
- Control of stock
- Management of controlled drugs

#### In-direct Services:

- Prescription monitoring
- Provision of Drug Alerts
- Policies and Procedures
- Drug Information Service

#### HMP Preston, Garth and Wymott

Pharmacy services are provided by an in house service located at HMP Garth and provide the same service as that described above and is open between 8am – 4pm each week day. All medicines ordered before 12md are delivered the same day.

Pharmacy technicians are also based on site at each of the establishments to ensure full compliance with Pharmaceutical Regulations, stock control and assistance with administration.

The Pharmacist also holds clinics for coagulation management (INR clinic) and skin conditions

#### 6.5.4 Physical Environment

The list below outlines primary care workspace available at each of the prisons. It does not include ward information.

**Table 29 Physical Environment (Rooms) in the Farms**

| <b>Lancaster Farms (Primary Care)</b> |   |
|---------------------------------------|---|
| <b>No.</b>                            | <b>Description</b>                                |
| 1                                     | Consultation Room (GPs and nurses)                |
| 1                                     | Consultation Room (GUM – also used by GPs/nurses) |
| 1                                     | Consultation Room (Counsellors)                   |
| 1                                     | Treatment/Medication Room                         |
| 1                                     | Dental Suite                                      |
| 1                                     | Admin/Reception Officer                           |
| 1                                     | Office (Nurses)                                   |
| 1                                     | Office (In-reach Team)                            |
| 1                                     | Office (Primary Care Manager and Counsellor)      |
| 1                                     | Staff Room  |

**Table 30 Physical Environment (Rooms) in Kirkham**

| <b>Kirkham</b> |                                 |
|----------------|---------------------------------|
| <b>No.</b>     | <b>Description</b>              |
| 1              | GP consultation room            |
| 2              | treatment rooms                 |
| 1              | Optician/Smoking Cessation room |
| 1              | Dental Suite                    |
| 1              | Mental Health Nurse Room        |
| 1              | Medical Records Room            |
| 1              | Pharmacy                        |
| 1              | Administration Room             |

**Table 31 Physical Environment (Rooms) in Garth**

| <b>Garth (including IDTS facilities</b> |                      |
|---|----------------------|
| <b>No.</b>                              | <b>Description</b>   |
| 2                                       | GP consultation room |
| 3                                       | treatment rooms      |
| 1                                       | Waiting room         |
| 1                                       | Dental Suite         |
| 1                                       | Primary care room    |
| 1                                       | Telemed Room         |
| 1                                       | Medical Records Room |
| 1                                       | Pharmacy             |
| 1                                       | Administration Room  |
| 3                                       | offices              |

**Table 32 Physical Environment (Rooms) in Wymott**

| <b>Wymott (including IDTS facilities</b> |                      |
|--|----------------------|
| <b>No.</b>                               | <b>Description</b>   |
| 4  | GP consultation room |
| 5  | treatment rooms      |
| 2  | Waiting room         |
| 1  | Dental Suite         |
| 1  | Telemed Room         |
| 1  | Pharmacy             |
| 1  | Administration Room  |
| 4  | offices              |

**Table 33 Physical Environment (Rooms) in Preston**

| <b>Preston (including in-patients and IDTS facilities</b> |                      |
|---|----------------------|
| <b>No.</b>  | <b>Description</b>   |
| 6   | GP consultation room |
| 5   | treatment rooms      |
| 1   | Waiting room         |
| 1   | Dental Suite         |
| 1   | Telemed Room         |
| 2   | Primary care rooms   |
| 1   | Administration Room  |
| 6   | offices              |



## 6.6 HEALTH SERVICE ACTIVITY

**Table 34: GP and primary care consultations in Lancashire prisons during 2010/11.**

| 2010/11           | Kirkham | Lancaster Farms |
|-------------------|---------|-----------------|
| New receptions    | 926     | 1780            |
| Second assessment | 926     | 1786            |
| Triage            | 4444    | 12275           |
| Administration    | 1831    |                 |
| Discharges        | 477     |                 |
| Seen by GP        | 2359    | 2810            |
| DNA at GP         | 152     | 249             |

Table 34 shows the high volume of nurse triages in relation to the number of prisoners seen by GPs.

### Comparison of Prisoner and Community Use of Health Services

It has not been possible to compare the local data relating to the usage of services with community data. However, in general, it is recognised that prisoners use health services more than those in the community. National figures show that prisoners:

- consult primary care doctors three times more frequently and other healthcare workers about eighty to two hundred times more frequently than young adults in the community.
- are admitted to NHS hospitals as frequently as young adults in the community.
- are admitted to prison in-patient facilities two to sixteen times more frequently than young adults in the community are admitted to NHS hospitals

The reasons for the increased usage of healthcare services among prisoners includes:

- Worry about their physical health and exaggerated concerns about the seriousness of the health problem.

- Access to informal care are limited (e.g. access to health information, advice from family members, over the counter medication etc.).
- There is little inconvenience normally associated with using formal care in the community.
- Some services (e.g. dentistry) may be more accessible than the community.
- Prisoners have little else to do with their time and time spent in a waiting room or seeing a healthcare worker may be preferable to spending time in a cell.

## 7. CORPORATE NEEDS ASSESSMENT

A corporate needs assessment was undertaken in each of the five prisons during May 2011 through the use of a questionnaire adopted from the one used by North Lancashire in their last full HNA in 2008. Responses were received from healthcare staff, prison staff and prisoners. **The responses represent the views, experiences and perceptions of those who completed the questionnaires and participated in focus groups.** The responses have been collated for each prison and presented below under the appropriate question.

**Table 35. Number of people who completed questionnaires/participated in focus groups.**

|                   | Kirkham | Lancaster Farms | Preston | Garth | Wymott |
|-------------------|---------|-----------------|---------|-------|--------|
| Health care staff | 6       | 5               | 5       | 6     | 4      |
| Prison staff *    |         |                 |         |       |        |
| Prisoners         | 0       | 0               | 0       | 14    | 9      |
| Total responses   |         |                 |         |       |        |

\* survey numbers too low to put in specific comments and numbers to avoid identification.

### 7.1 SUMMARY STAKEHOLDER RESPONSES:

- In general there is an understanding of what constitutes health in its widest sense i.e. lifestyle, social relationships, hygiene, health literacy etc
- There is a strong focus on access to health care and there is a majority view that access to the services received within the prisons are broadly equivalent, if not better than that in the community.
- However certain gaps in provisions such as self management and over the counter remedies and access to allied health professionals is highlighted along with the view that more primary care mental health and alcohol services are required.
- There is cross prison acknowledgement of the wide range of services commissioned within the prisons.

- There are consistent concerns over the requirement to balance the needs of a prisoner's health care within the requirements of a prison environment in a mutually beneficial manner.
- Benefits to effective healthcare could be achieved through the provision of multi professional case conferences and meetings.
- There is recognition of the need for, and identification of, opportunities to provide health promotion within the prisons however there is also some belief that this is the responsibility of health care rather than a whole prison approach.

## 7.2 WHAT THINGS CONTRIBUTE TO HEALTH WITHIN A PRISON ENVIRONMENT? DOES THE PRISON ALLOW FOR THESE FACTORS?

### 7.2.1 Lancaster Farms

There is a general understanding amongst the range of respondents that health is determined by a range of lifestyle and social factors including good nutrition, physical exercise; timely access to healthcare including optician, dentist and sexual health services; health promotion; good communication between all departments; peer involvement and clear protocols and ways of working.

In terms of matching the provision available in the community, sometimes in the prison this can both fall short of this and also exceed it. It is difficult in the prison to allow for the many factors that arise from the differing professionals involved with delivering the whole package from both a health and security perspective.

All aspects of a person's need for physical, emotional, mental and social wellbeing contribute to health when a person is located within a prison environment. Lancaster Farms allows for all these factors. Healthcare staffs liaise with multi-disciplinary staff members to achieve positive outcomes for each person's individual health need. There are mental health nurses, chaplaincy staff, family links, general practitioners, personal officers, wing officers, psychiatrists, education and gym staff etc who liaise with each other if required to achieve a positive health needs outcome. All this is dependent on good leadership within departments.

### 7.2.2 Kirkham

There is a general understanding amongst the range of respondents that health is determined by a range of lifestyle and social factors including: access to fresh air, exercise, work, healthy diet and strong family relationships, gym activities – including exercise on referral and remedial work, opportunities for leisure and sport, family connections and visits, availability of staff members to listen and support. It is considered that the prison provides access to all these, although there are challenges in matching the provision available in the community. Sometimes in the prison this can both fall short of this and also exceed it. It is difficult in the prison to allow for the many factors that arise from the differing professionals involved with delivering the whole package from both a health and security perspective.

Within one week of reception, offenders attend the sports centre for an induction. Within this induction, as well as being advised of the general rules, attendance times and an introductory session regarding the equipment and resources, offenders have a one to one interview with a member of the PE Staff. Prior to this interview the offender, with support from the PE Staff, where appropriate, will have completed a Preparation Activity Readiness Questionnaire [PARQ]. This simple questionnaire allows the offender to disclose any underlying physical condition that may have an influence on the physical activity he wishes to undertake. It also provides the member of staff sufficient information, in most cases, to advise the offender and guide him to the most appropriate session or class.

The department facilitates sessions that meet the particular needs of individuals, for example, weight management, older prisoners, remedial and treatments in the form of sports therapy.

The department also manage, with the aid of offenders working in the sports centre, a well man clinic. Simple tests are conducted such as height and weight, and when it is felt necessary offenders are referred back to PE Staff.

In regard to monitoring and assessing the wellbeing of offenders, the PE Department works closely with the PCT in the establishment.

It is felt that Mental Health and Alcohol provision could do with additional resourcing and provision.

### 7.2.3 Preston

There is a general understanding amongst the range of respondents that health is determined by a range of lifestyle and social factors and that health in a prison reaches to all departments and in to some of the real fine detail of each working environment and practice. However in relation to reducing reoffending Health is one of the primary pathways and should include interventions/ services for prisoners and training for key stakeholders. The following were identified as the most important:-

- Drug Services – Preston & Partners provide some really good intervention/ service in this field however a more joined up approach aimed more at recovery is needed.
- Mental Health – some brilliant work and services in this area however although it was felt that more needs to be done in terms of awareness raising and the training of all staff to support those with mental health illnesses. (non medical staff being the target area)
- Alcohol Services – primary care is available and symptomatic relief is offered/ prescribed when needed however there is an indication that the British binge drinking culture has a direct impact on violent offending and often more so with domestic violence. Preston does not offer any interventions for this type of offender. The offender with entrenched alcoholism can engage with AA or do alcohol awareness course, as can a alcohol related violent offender, but this is limited and does not meet the need of our population. It was felt that the department of health should provide services in this area as a priority.
- Physical health is delivered via the gymnasium department and they try hard to encourage all to engage. There seems to be a good link between the health service provider and the gym with good referral processes in place.
- Diet and Nutrition is something that several departments contribute to (Kitchen, HCC, Gymnasium, education etc) but perhaps a more joined up approach in delivery would be beneficial.

It was felt that a culture of Care and well being contribute to health in the prison environment and that this was allowed for. Partnership working with both prison staff and partner agencies, understanding of the client group (transient population), Knowledge of staff especially around chronic disease, BBV, drug use and mental

health, good working relationship with prison governors, understanding and acceptance that security requirements can/may override healthcare needs, good leadership and communication from managers both operational and senior, support from PCT colleagues and managers.

To an extent the Prison does allow for a lot of these factors and a good relationship between health and the Prison SMT exists. Where it falls down is during day to day tasks when healthcare staff are unable to deliver certain health services because of a reluctance of some prison staff to assist in getting patients to appointments etc. Some staff report that Prison staff put them under a lot of pressure to make decisions that are in the best interest of the Prison and not necessarily the patient, which causes a great amount of anxiety for some staff (an example of this is when a prisoner may need to go out to hospital and the prison do not have full staffing levels e.g. after 5pm and on the weekend)

As part of the action plan to address self harm, suicide and other health concerns, a newly commissioned Primary Care Mental Health/Crisis Nursing Team has been established at HMP Preston Prison. The team consists of a PMHT Manager, 4 Band 6 Registered Mental Health Nurses, and a Primary Care Mental Health Worker (formerly Graduate Worker”) and 2 part time counsellors. One of the primary aims of this team is to provide better crisis care to prisoners, to improve overall mental health of prisoners and reduce suicide and self-harm rates. As part of the Primary Care Mental Health/Crisis Nursing Team, there is a responsibility to ensure that all procedures follow evidence-based practice as in any health care setting. This is achieved by taking current or recent research findings and integrating them with legislation and guidelines to ensure that the best overall care is offered to each patient.

It is believed that the alignment of service provision to the dynamic need of offenders is key- therefore a continuous appraisal should take place around meeting need, It is clear that if we aspire to meet the parity of treatment in custody with community then access to the service is key and equivalent waiting times should be targeted. Health Education needs to be progressed as a priority, not just in the delivery environments but more in the living areas. DNA's remain a big loss of precious resource, and more should be done to investigate and ensure the physical aspects and barriers of being incarcerated do not get in the way of patient care and the right to treatment. My experience is that the biggest barrier to 'getting ahead of the game' around health is the constant lack of staffing, despite all efforts to improve services, regularly we see clinics that are about health monitoring and promotion fall away when vacancies through turnover or long term sickness are not forecast and filled expediently.

#### 7.2.4 Garth

There is a general understanding amongst the range of respondents that health is determined by a range of lifestyle and social factors (including meaningful activity, social contact, stress levels, health illiteracy, fresh air and exercise) – although the importance of effective healthcare services are stressed – including timely diagnosis and treatment. The need for consistency in doctors and dentistry is also considered an issue.

There is clear recognition that the need for security conflicts with health but it is possible for prison staff to think about health in a way that does not necessarily just involve healthcare. The importance of the gymnasium as a health promoting department was noted.

#### 7.2.5 Wymott

There is a general understanding amongst the range of respondents that health is determined by a range of lifestyle and social factors **including** exercise, food which is available in the prison 'to an extent'; proper work – although many cannot access this; and limited education. Access to support for Faith is available but under accessed.

Mental health needs are identified as important but there is insufficient capacity to meet the demand. The process of accessing healthcare is seen as problematic with delays, slips to wings not getting through on time, drug supply erratic, doctors insufficient, nurses over stretched, and a perceived overreliance on Paracetamol.

However there is seen to be effective delivery of Healthcare services by medical staff, which are properly integrated within the prison's regime and Residential services delivery arrangements and effective multidisciplinary support for the emotional and physical health of prisoners, underpinned by a decent, as-safe-as-possible and consistently delivered regime which treats prisoners with respect, and offers them the opportunity and encouragement to lead better lives and to change their offending behaviour.

Other health determinants include:

- a good diet and regular opportunities for exercise and other physical activity.
- A clean, safe environment
- Meaningful activity – for some
- support and opportunities to maintain ties with family and friends, and to develop effective arrangements for resettlement following discharge.



Wymott endeavours to deliver these various factors, although probably not quite as systematically as might be desired in an ideal world. It is felt the prison environment does not always help though this is little to do with individual establishments but the balance of security. Prison staff need to be aware that they can influence health which can be seen as the responsibility of the healthcare dept.

### **7.3 ARE HEALTHCARE SERVICES WITHIN THE PRISON EQUIVALENT TO THOSE FOUND IN THE COMMUNITY?**

#### **7.3.1 Lancaster Farms**

The whole environment is very different, but generally it was felt that the Healthcare services within Lancaster Farms are equivalent to those found in the community. To access healthcare there are “healthcare applications” which can be completed by prisoners located on the wings and posted to healthcare. The applications list all services available (e.g. Chlamydia screening, sexual health nurse, Doctor appointment, nurse appointment, smoking cessation, dental waiting, optician request, repeat medication requests. Healthcare also have regular clinic running throughout the day e.g. nurse triage clinic, asthma clinic, Hep B vaccination clinic, G.P clinic, GUM clinic and dental clinics (Mon-Wed-Fri).

Access to emergency dentist, the optician and sexual health service is limited, but access to a nurse more available than in the community. There is a high demand for healthcare services compared to the community and the set up allows good if not better access than in the community. However, the fact that prisoners are locked up results in difficulties in accessing some aspects of healthcare that might be accessible to them in the community: advice from friends/family/pharmacist for instance. Mental health needs and the vulnerability of some prisoners is also difficult to manage.

#### **7.3.2 Kirkham**

It was felt that generally they are and in some cases better than those in the community, although out of hours and weekend cover is not extensive. However, referral to hospital and daily surgeries is probably quicker than in the community. Healthcare services at Kirkham are superior to those in the community in terms of the

length of time to wait for appointments, and the amount of availability of services far wider and easier to access.

### 7.3.3 Preston

It was generally felt that they are similar and in some cases better services are provided in a prison. For example the mental health crisis team are immediately on hand to support individual cases where as in the community this can often take several weeks. It is also believed that a prison environment is very different to the community and should in some cases provide a better or more intense service thus enabling the rehabilitation process to have good effect and therefore reduce the risk of re-offending in some cases. This in turn would make a saving for the community they return to. However concerns were raised about access issues – ‘the ability to see a doctor/ dentist is difficult in the community, add to this the prison environment, waiting times, cancelled clinics, poor GP contracts that rely on locum and agency staff- make this aspiration, in my view, distant’.

Some of the services offered within the prison which are considered better than those offered in the community include sexual health, BBV, and quicker access to hospital consultants via telemed. It is also recognised that both prison and community provision are undertaking a period of change and how this will impact on services will have to be evaluated. Currently regarding primary care mental health the services provided waiting lists for assessment is usually around 3 weeks counselling can be up to two and a half month. Crisis’s are seen within four hours and due to the environment this is usually immediately. Computerised CBT could be afforded to the prisoners which would benefit them but due to concerns raised by security around access to computers this still has not been authorised. Groups are also difficult to facilitate due to requiring Prison staff to facilitate large groups and room space is often a problem.

### 7.3.4 Garth

There were mixed responses to this issue – in some cases healthcare provided at Garth is on a par with the services in the community – within the constraints of the environment.

At the primary care level there is a reduced element of choice as prisoners do not have access to over the counter remedies which you would access through a pharmacy.

There is a lack of surgeries staffed with regular GP's and the prisons within central Lancashire use locum GP which means there is a lack of consistency.

There is a reduced access to consultation and treatment within secondary care due to the rationing of escorts for prisoners who need to be seen in the local hospital.

There is some equivalence in mental health though offenders do not have access to a psychiatry service for older adults and there is no commissioned LD service.

### **7.3.5 Wymott**

Emergency access to services is probably better than in the community, more routine access is likely to vary in accordance with the current development of individual services, e.g. relative lack of consistent GP cover and related relationships; long-running difficulties with dental waiting lists; and (up until quite recently) previous limited expertise and services for learning disability and alcohol. There is a reduced access to consultation and treatment within secondary care due to the rationing of escorts for prisoners who need to be seen in the local hospital.

At the primary care level it is felt that there is a reduced element of choice as prisoners do not have access to over the counter remedies which you would access through a pharmacy.

## **7.4 WHAT ARE THE MOST FREQUENT ISSUES THAT ARISE IN RELATION TO HEALTHCARE?**

### **7.4.1 Lancaster Farms**

- Difficulty in referring due to concerns about transport both from a cost perspective and a security one.
- The most frequent issues arising in healthcare are: emergency calls from wing staff requesting a nurse to assess prisoners on the wing, administration of medications, triaging reported sick prisoners, assessing self harm/mental health issues, reviewing prisoner's health care needs in clinic, attending appropriate training to deliver effective healthcare provision.
- Toothache, Headaches, Acne. Skin conditions Seasonal hay fever
- Miscommunications and difficulties with continuity of care.

### 7.4.2 Kirkham

By far the biggest identified issue is substance misuses. This can manifest in Prisoners pressuring GP's and staff to prescribe opiate based and strong synthetic medications when there are other options available. The possibility of being misled around health issues for gains that are perceived to be available to prisoners in certain circumstances. Chronic pain is a good example of this.

Men complain about not getting to see the Doctor quickly enough, even though the expectation is probably unrealistic in terms of comparison to accessibility to services in the community. Other difficulties involve medication collection times and restrictions and issues with referral to secondary care due to concerns about transport both from a cost perspective and a security one.

Issues pertinent to the sports centre are mainly around weight loss and general fitness. There is also an issue about challenging perceptions of fitness and general health within a prison gym. There still remains an attitude that the centre is full of people lifting heavy weights, however over 80% of offenders attend the sports centre at least once a week.

### 7.4.3 Preston

Issues identified include:

- Drugs
- Alcohol
- mental health and self harm
- Medication (particularly analgesia),
- chronic disease and undiagnosed long term conditions eg. diabetes, angina, asthma.
- BBV
- Sexual Health,
- back pain,
- leg ulcers.

It is reported that some Prison staff undertake a 'triage' function - diagnosing patients themselves - which at times causes difficulties with providing appropriate care for the prisoners. Appointments are often missed due to being at work as prison staff don't

bring them over. The ACCT document (self harm observations) is a MDT document but at times it can be medicalised by Prison staff

Some identified difficulties include high rates of 'Did Not Attends'; GP Contracts; inappropriate referrals to A&E; Staffing shortages, assumed Personality Disorder diagnosis, Methadone levels and prescribing anomalies.

#### **7.4.4 Garth**

Generally responses related to insufficient services to meet the need in relation to both physical and mental health and also the lack of consistent GP services, long waiting lists for both GP and at times dentistry. A lack of a structured strategic partnership was highlighted, underpinned by sound intelligence to inform commissioning decisions. The regular use of Telemeds was recommended.

Underlying substance misuse issues were identified with prisoners with a dependence upon prescribed medication making demands. It was also recognized that, in difficult situations, there were tensions between healthcare and prison security requirements that have the potential to cause misunderstanding and disagreement between the prison and health staff.

#### **7.4.5 Wymott**

The main issues are identified as: access to services are due to escorting between residential areas and healthcare centre; appointment slips not being delivered in a timely fashion resulting in prisoners missing their appointments; some issues with poor communication; routine GP surgery access issues; drugs and alcohol issues; mental health; support for elderly and disabled prisoners; support for learning disability; prisoners with a dependence upon prescribed medication making demands.

Sometimes, in difficult situations healthcare can be viewed as an annoying consideration by the senior management team which can then cause conflict between the prison and health staff.

## 7.5 DOES THE PRISON 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 WHILST IN CUSTODY AND HELP PRISONERS ADOPT HEALTHY BEHAVIOURS THAT CAN BE TAKEN BACK INTO THE COMMUNITY UPON RELEASE.

### 7.5.1 Lancaster Farms

**Generally** - Yes, the prison does. There is always a multi-disciplinary approach provided to address the needs of a prisoner's health. ACCT assessments are usually multidisciplinary as required although there is no counselling service and no provision for primary care mental health which includes non pharmacological therapies. There are also examples of occasional poor attitude of staff to prisoners with mental and physical health problems.

There are numerous monitoring systems in place at Lancaster Farms to ensure that any deterioration of a prisoner's health is documented and effectively communicated between all team members (e.g. first reception screening, opening an ACCT document which could highlight any trigger dates which may cause a deterioration in a prisoner's health, reviewing prisoners in reception following being sentenced to assess their current mental health and physical needs, assessing in clinic due to reported low mood, referring to other members of the multi-disciplinary team if required for support.

Through the YOI the Chlamydia screening team is able to opportunistically test young males who would ordinarily be difficult to access within the community but who are at risk of the infection. The positivity rate at the YOI is high. We are able to treat individuals who test positive and hopefully help prevent complications in later life relating to the Chlamydia infection.

There are lots of courses and groups that the prisoners can attend to enable positive thinking and to help them adopt healthy behaviours upon release (resettlement courses, attending discharge clinic to empower prisoners about forthcoming release and to answer any concerns that they may have)

The Discharge clinic is being expanded to give health promotion and help promote the importance of accessing healthcare in the community.

CARATs and Addaction are available to support those with drugs and alcohol issues.

Smoking cessation available

Making young people take responsibility for their health – application process and requesting repeat medication.

With regards to Chlamydia screening patients testing positive will be advised around preventing re-infection, safer sex and the importance of contact tracing. Hopefully all individuals who access a test at the YOI will have increased awareness of Chlamydia and this will serve to help control the spread of the infection in the community.

### **7.5.2 Kirkham**

It is generally felt that a good multi-disciplinary approach exists and attempts are being made to make it a whole prison approach and more joined up. Actions are planned to make this more effective. Regular meetings are held that focus on offenders wellbeing as well as the Queensland committee, in which many issues of health are discussed including diets and mental health needs. There remains room for improvement in terms of inter-departmental cooperation.

For some prisoners, custody may possibly be the first time their health needs have been screened, the initial interview with health care staff and the PARQ's in the sports centre are an example. Other supportive measures are available such as CARAT's , PASRO and the listeners programme are in place.

The aforementioned substance misuse issues are seen to be overwhelming the primary care services, showing drug seeking behaviours that are not always dealt with in an appropriate way, or with a joined up approach with other prison departments such as the drug support team.

A healthy food approach is adopted which will hopefully stay with men upon release. Most men are encouraged to use the gym and adapt a change of lifestyle. Men are encouraged to continue these changes when released.

Family days are centered on healthy lifestyles, often including sports activities and healthy eating.

### **7.5.3 Preston**

It was felt that the prison tries to achieve these factors, but in a very difficult environment. The present financial climate is making this work even more challenging.

It was seen mental health was promoted however there is a great reluctance by some prison staff to address social needs of prisoners and quite often this is seen as a healthcare issue. There are always individuals whose mental health deteriorates

during custody. These men are often non-compliant and are therefore not easy to deal with.

With regards to physical health the prison view this as falling under healthcare and it could be built upon more, the exception would be the gym staff who do a lot of work around health and they also work in partnership with healthcare to deliver smoking cessation

Health promotion generally is perceived as a healthcare issues, however Preston have recently launched the healthy settings group to try and make it a prison partnership task rather than a healthcare one.

#### **7.5.4 Garth**

It was recognised that there are significant limitations on the ability to create a healthy environment, but considerable effort is made in supplying activities for physical health. There is a sense that the establishment is less equipped to deal with the levels of mental health problems that exist. It aims to, but a prison regime, especially one that is limited by financial constraints, is not conducive to good health.

Facilities for physical activity, employment, healthy diet options and a clean safe environment are provided, however this is not enough to prevent a deterioration in some prisoners mental and physical health. Garth is a long term prison and some of the prisoners will spend many years in custody

Exercise and a healthy diet are encouraged and courses and treatment which help address substance misuse are provided. More support from the PCT to improve in this area would be welcomed.

#### **7.5.5 Wymott**

It was felt that the above is hindered by inadequate communication and trust between health care and the rest of the prison, although it was recognised that the prison agenda tries to point in such a direction. It was felt that encouragement and opportunities to promote health are generally provided, but are constrained by the environment.



## 7.6 HOW EASY IS IT FOR PRISONERS TO ACCESS A HEALTH PROFESSIONAL?

### 7.6.1 Lancaster Farms

It is generally considered easy for prisoners to access a health professional when required. There are “healthcare applications” which can be completed and posted to healthcare for prisoner’s requesting to see a nurse etc as a non emergency appointment. If a prisoner is unwell he can report immediately to the wing officer’s first thing in the morning and he will be seen by a nurse on the wing or at their place of work within the prison depending on the time slot.

There are sometimes inappropriate referrals from officers. Repeat visits to nurses in education and VTC to try to be rested in cell. Seen on triage session when an application would have been more appropriate.

There is a large waiting list for optician and sexual health nurses

The GP list is sometimes up to a week long, non urgent cases can be moved several times to facilitate urgent patients – this would not be done at their own GP surgery.

From the aspect of treatment for Chlamydia – regular GUM sessions can facilitate treatment and the project nurse is granted access to treat positive patients, this is within 14 days (as per the national standard) Staff are always supportive of the screening activity at the YOI, this is appreciated by the project as it allows us to access a very high risk group of individuals and positivity from the site is high. In terms of well being for prisons identifying and treating positive patients means that future complications such as infertility are much reduced.

### 7.6.2 Kirkham

Access is generally perceived to be much easier than in the community - doctors attend on a daily basis as well as experienced PCT staff being available.

### 7.6.3 Preston

Generally it is easy. There is a large, experienced nursing team here 24 hours a day. Some prisoners will argue that it is not easy and this is usually due to them not liking the advice/information given and wanting to see someone else for a different answer (usually the GP)

The GP waiting times are currently high, 2-3 weeks, however there is a disproportionate amount of DNA appointments at Preston which is currently being looked into. There is a full time Nurse Practitioner who is also a prescriber and this role has allowed us to manage the waiting list effectively until recently when we have had a staffing crisis and her resource has been allocated to cover the PC dept. Most staff members and prisoners are aware of how to access health services which are contactable by phone and prison radio.

However there are also many barriers - no open clinics, lots of conversations on hoof/ opportunistic healthcare. People in prisons by their nature are reliant on others, where health is concerned the processes are all around Prisoners convincing a prison officer that they are ill, getting to see a nurse (normally at the treatment hatch after medication issue), being told that they will be placed on a list and then having to wait to see if they get an appointment slip.....and then hope that they are available, in their cell to attend.

#### **7.6.4 Garth**

Prisoners can make an application or be seen if there is an emergency, many complain that they cannot see the doctor or about the length of time it takes to see a dentist and GP cover has been a problem.

#### **7.6.5 Wymott**

This was felt to be not particularly easy by some and not others. It was suggested that a 'one stop number' would facilitate this.

### **7.7 HOW CAN PRISON STAFF CONTRIBUTE TO THE WELL-BEING OF PRISONERS?**

#### **7.7.1 Lancaster Farms**

- By concentrating on increasing their responsibility for their own health.
- By having a better understanding of healthcare and the services provided, understanding the nurse's role and referring to healthcare appropriately. However, in general, the officers provide an excellent point of contact on the wings and are effective in referring any prisoners whom they feel require individual health care attention by healthcare staff.

- Better attitude to those with health care needs, more education about mental health issues and communicable diseases.
- Be more helpful in facilitating the movement of patients to nurses and healthcare for clinics and the administration of medication.
- Some prison staff do not see the well being of the prisoners as being of high importance. They probably do not see the link between rehabilitation and well-being.

### 7.7.2 Kirkham

- Access to diet
- Access to peer support
- Access to advice and support
- By being aware of change in prisoners – especially around mental wellbeing.
- By concentrating on increasing their responsibility for their own health.
- Gym staff provide activities and advice for fitness, diet, exercise, injuries and also provide activities for older men.
- The kitchen provide a healthy balanced and varied diet.
- Prison staff monitor and report and prisoners that cause concern
- Staff are provided with mental health awareness training to help them recognize behaviour changes and conditions.
- Listeners and mentors are available for all prisoners experiencing difficulties.
- Staff contribute to the well being of offenders in many ways. Through experience they identify and support prisoners through difficult periods in their sentence, in particular personal officers. The access to the sports centre and other activity based areas such as the trim trail. Other supportive departments, the chaplaincy, education and the library.
- Limitations are placed on staff due the current environment of economizing; staff themselves will experience low levels of morale and will have less time to deal with sensitive situations.
- A general more 'joined up' approach would be highly beneficial. If general information could be given to prison staff more freely, both parties could work together to ensure the well being of prisoners is more of a priority.
- By supporting the health education agenda i.e. it is not just unlawful to take cannabis, heroine etc., but it is harmful to prisoner's short and long term health prospects.

### 7.7.3 Preston

Residential officers, if given appropriate training, could engage prisoners to adopt a healthier lifestyle, for example: wing competitions during association, nutrition and diet days. Visits could have healthy setting family days etc

Care – it is all in the approach and the gentle persuading.

Confidence - being confident in the services the Health Professionals provide.

It is acknowledged that there needs to be an acceptance that all staff regardless of employer/role must view the prisoner holistically and not just concentrate on the prison staff/prisoner role. Preston has started to improve some aspects of this especially around disabled prisoners which have historically been seen as a 'medical issue' however more work is required.

For prison staff to address the issues for the prisoners in a timely fashion to prevent crisis intervention by healthcare staff if they escalate, and to be more supportive towards healthcare staff, recognizing their skills and experience.

Having clear systems to adhere to around referrals, knowing when an open clinic is available - arrangements change daily due to strains on the service and operational deviations.

Most staff as a first call will try and get the prisoner down to treatment dispensing areas to see a nurse rather than an arranged venue where the time is available to triage and appropriately refer. The most a Prisoner may get is a verbal "I'll put you down to see the doctor", they walk away thinking... Will I see a GP and when.

### 7.7.4 Garth

"Staff help to provide a clean and safe environment, they can also encourage prisoners to adopt healthier lives and refer them to medical services if they see the need for them."

Helpful answers, support with concerns and personal problems, guidance to relevant information, offering Gym sessions, delivering Offending Behavior and with the promotion of drug rehab communities.

### 7.7.5 Wymott

It was felt to be helpful if staff had a better base knowledge of the health services available so that they could sign post prisoners to the appropriate service. Attention to prisoners and effective liaison with health care and encouragement of total prisoner well being were also suggested.

## 7.8 WHAT TYPES OF SUPPORT AND SERVICES IN THE PRISON ARE REQUIRED TO MEET THE NEEDS OF THE PRISONERS?

### 7.8.1 Lancaster Farms

- Electronic prescribing.
- The prison is already very well equipped to deliver support and services to prisoners to meet their health needs. However, the two services that are felt to be more high demand are the dental service and the smoking cessation service which can have high waiting lists.
- Counselling
- Cognitive behavioral therapy
- Sexual health promotion.
- Regular neurology clinic.
- Regular orthopaedic clinic.
- Regular physiotherapy clinic.

### 7.8.2 Kirkham

- Prisoners need to have more access to self help systems such as expert patient programmes
- Pain management programmes which do not include medication.
- Need for more informal counselling and support services.
- Electronic prescribing
- Already in place: BME community worker, mental health worker, external partnerships, dentist, doctors etc...
- More time!! More focus on health has an issue rather than learning and skills and employability, or a realization that a health issue may take priority.
- Alternative pain management systems / programmes without reliance on medication.
- More joined up working between healthcare staff and the substance misuse team to identify those that may be being prescribed medication that is not appropriate to their substance histories.
- More prisoner / healthcare forums where issues can be discussed and resolved.
- Increased Mental Health and Alcohol intervention provision

### 7.8.3 Preston

- More multi-disciplined conferences between the departments.
- More social care input especially around 'poor copers' who are being released.
- A substantive GP is the main priority at the moment to avoid reliance on locum GP's
- Improve the prescribing of analgesia
- Psychological Input would be beneficial
- CBT
- Enhanced multi-disciplinary Case Reviews to deal with difficult prisoners
- Occupational therapist to assist and help participate in facilitated groups to provide purposeful activity to prisoners with mental health problems.
- Learning Disability Nurses to provide outreach and support for current and to be include in provision of care as at times contact with services outside is disjointed and difficult to refer to.
- To provide more group and therapy sessions
- A clinic appointment system is needed- an IT driven clinic appointment system where in real time patients can be informed of their appointment time. This will offer confidence in the system.
- A staffing contingency for vacancies and sickness, it is not acceptable to curtail the planned provision following these mostly predictable shortfalls.
- A full time directly employed GP, who knows the prison environment, can consistently prescribe to local protocols and understands how important health is in a custodial environment.

### 7.8.4 Garth

- Regular GP and sufficient dental treatment.
- Facilities for X-ray and physiotherapy to be provided on site
- Regular needs assessment
- Increased capacity to address the mental health (including personality disorder) problem so many of my prisoners have.
- Access to specialists in some of the disorders that are over represented in the prisons such as: ADHD, ASD, neuropsychiatry/psychology.

- Access to people who can provide risk reducing interventions for prisoners who are denied access to offending behaviour work due to low intelligence, mental health problems etc.

### 7.8.5 Wymott

- Mental health visitors, information/training in basic recognition of mental health needs.
- On site physio and x-ray / scanning services
- Access to specialists in some of the disorders that are over represented in the prisons such as: ADHD, ASD, neuropsychiatry/psychology.
- Also access to people who can provide risk reducing interventions for prisoners who are denied access to offending behaviour work due to low intelligence, mental health problems etc.

## 7.9 PRISONER QUESTIONNAIRE RESPONSES

### 7.9.1 Garth

#### **What does “being healthy” mean to you?**

Descriptions of ‘being healthy’ included: exercising and being fit, being free of illness in body and mind, being able to look after ourselves, eating good varied foods; having a positive attitude and plenty of sleep; not taking drugs; good personal hygiene, living a healthy lifestyle, avoiding alcohol; not smoking; avoiding stress

#### **Do you think you are healthy?**

Most of the respondents felt that they were healthy with some describing themselves as a ‘little overweight’.

Only 1 respondent described himself as ‘not really healthy’

On a scale of one to 10 (1 being unhealthy and 10 being very healthy) scores ranged from 3 – 10 with a mean score of 7.6

#### **What things are important for good health?**

- Good healthcare

- Healthy eating/good balanced diet – with appropriate options to meet dietary needs
- Plenty of exercise and more fresh air
- Accessing the gym
- Safe sex
- Avoiding drug abuse
- Life style choices and personal hygiene
- Not smoking
- Less stress
- Good living environment

**What could be done in the prison to make people more healthy?**

Suggestions included:

- Better healthcare
- Positive health promotion
- Health education – including calorific values of foods and rationing sweet products
- More healthy menu - lower fat meals.
- More exercise/gym access
- More day to day activity and association time
- Better visiting conditions

**If you had a problem with your health, who would you go to first?**

Most reported Doctor as the first port of call followed by mates, family, nurse or wing officers and, in one instance, teacher.



### How important do you think the following are to keep people healthy?

|                                | Not Important | A bit important | Quite important | Really important |
|--------------------------------|---------------|-----------------|-----------------|------------------|
| Jabs                           |               | *               | *****           | *****            |
| Exercise                       |               | *               | ****            | *****            |
| Good/healthy foods             |               |                 | ****            | *****            |
| Nurse/Doctors/Dentists         |               | *               | *****           | *****            |
| Friends to talk to             |               | *****           | ****            | ****             |
| Advise on being healthy        |               | *               | *****           | ***              |
| Safe sex                       | **            | *               | **              | *****            |
| Good buildings and environment | *             | *               | *****           | *****            |

### Have you been to the Healthcare Department?

All respondents had attended the healthcare department and rated it between a score of 4 – 8 – with an average score of 6.6

### What was good?

Staff; Paracetamol/medication; Seeing the doctor

### What was bad?

The most common complaints related to the waiting area, the amount of time allocated, lack of toilet facilities, waiting times, waiting lists, no emergency appointments, limited dentistry, unable to get medication, lack of after care, poor prescriptions

### Have you ever been to a doctor or nurse outside the prison

All had experienced healthcare outside of prison and with one exception the comparisons were that outside care was better than that in prison – with the main issues being how an individual was treated

### What single thing would help make you more healthy?

More prompt treatment

Better choice of food – less greasy, more fruit/veg choices

Regular Exercise and not sitting in the cell too long/more gym  
 Fresh air; sunlight  
 Stopping smoking  
 Shower in cell

**Are any of these problems in here?**

|                     | Not a problem | Small problem | Big problem |
|---------------------|---------------|---------------|-------------|
| Bullying            | *****         | ****          | *           |
| STD's               | *****         |               |             |
| Drugs               | ****          | ****          | ***         |
| Depression/low mood | ***           | *****         | **          |
| Alcohol             | ****          | *****         |             |

**Do you think any of the following would be useful?**

|                                  |       |
|----------------------------------|-------|
| More Doctors/nurses              | ***** |
| Male Healthcare Staff            | ***   |
| More contact with family/friends | ***** |
| More exercise                    | ***** |
| A ban on smoking                 | ***** |

**And what about more advice on**

|                           |       |
|---------------------------|-------|
| How to stop smoking       | ***** |
| Sexual and physical abuse | ***   |
| Being a father            | ***   |
| Managing money            | ***   |
| Dealing with anger        | ***** |
| Feeling low/depressed     | ***** |
| Safe Sex                  | **    |

**Anything else?**

- Wages low – not allowing maintenance of health
- Better opportunities for outdoor exercise – running

- Smoking cessation more widely available

#### **Other comments**

- Eggs for breakfast
- More transparency in healthcare

### **7.9.2 Wymott**

#### **What does “being healthy” mean to you?**

Descriptions of ‘being healthy’ included: ‘being fit enough to work and live without pain or discomfort’; ‘not needing to see a doctor or nurse’; ‘free of illness in body and mind, enough to go about your normal day to day activities’; ‘being in good health’; ‘being able to look after ourselves the right way and to get what we require’; ‘looking healthy and knowing information’; ‘being physically fit, eating good varied foods and exercising for 20/30 mins per day’; ‘a happy and fun life’;

#### **Do you think you are healthy?**

Most of the respondents felt that they were healthy ‘generally’ or ‘to a degree’, although some reported ‘a few mental health issues’ or that they were ‘a little overweight’.

Some reported that they were fitter than before they came in.

On a scale of one to 10 (1 being unhealthy and 10 being very healthy) scores ranged from 6 to 10 with a mean score of 8.2

#### **What things are important for good health?**

- Medical help when required - Being seen quickly
- Healthy eating/good balanced diet – with appropriate options to meet dietary needs
- Plenty of exercise – getting out of cells more or more fresh air
- Fresh water to drink
- Less stress and quiet time
- Diabetic foods options needed

- Good living environment

### What could be done in the prison to make people more healthy?

Better waiting times for appointments

More healthy menu – ‘it’s either full of grease or sugar’; ‘less stodgy food’; fresh food.

More access to buy what we need - i.e. health foods, weight protein for gym users.

More promotional diets, posters, exercise (in cells)

More outdoor activities/gym access/better gym regime and more staff in gym

Better use of the facilities around the fields, i.e. football pitch, assault course.

Better mental health help

### If you had a problem with your health, who would you go to first?

Most reported Family as the first port of call (as reported ‘most staff in all departments shows no interest’); followed by doctor, nurse or wing officers.

### How important do you think the following are to keep people healthy?

|                                | Not Important | A bit important | Quite important | Really important |
|--------------------------------|---------------|-----------------|-----------------|------------------|
| Jabs                           |               | *               | ***             | ****             |
| Exercise                       |               |                 | ***             | *****            |
| Good/healthy foods             |               |                 | **              | *****            |
| Nurse/Doctors/Dentists         |               |                 | *****           | ***              |
| Friends to talk to             | *             | **              | *****           |                  |
| Advise on being healthy        |               | ***             | *****           |                  |
| Safe sex                       | *             | *               | **              | ****             |
| Good buildings and environment |               | **              | ***             | ***              |

### Have you been to the Healthcare Department?

All respondents had attended the healthcare department and ratings ranged from 3 – 8 with a mean score of 4.5

### What was good?

Clean and tidy, Polite Service

We have one  
 Seeing the doctor  
 Separate sections for VP's and TV  
 Diagnosis and quickness of receiving medication for the illness  
 Eventually a "GOOD" nurse with some compassion and time to listen to a very  
 "Simple" request for advice

### **What was bad?**

The most common response was waiting times and overcrowding in the waiting room with a lack of leaflets in the waiting area. Incorrect or undelivered slips were also an issue and escort issues preventing a prompt return to the wing. Some reports of impatience of staff and poor treatment.

### **Have you ever been to a doctor or nurse outside the prison**

All had experienced healthcare outside of prison and the comparisons were all that outside care was better than that in prison – with the main issues being how an individual was treated 'Outside you are a person, in here you're a number'.

### **What single thing would help make you more healthy?**

Easier Doctor/Dentist appointments.  
 Regular Exercise and not sitting in the cell too long  
 Better access to a Sex Therapist for gay, transgender and undecided

### **Are any of these problems in here?**

|                     | Not a problem | Small problem | Big problem |
|---------------------|---------------|---------------|-------------|
| Bullying            | **            | ***           | ***         |
| STD's               | ***           | **            |             |
| Drugs               | *             | ***           | ***         |
| Depression/low mood |               | ****          | ****        |
| Alcohol             | ****          | ***           |             |

**Do you think any of the following would be useful?**

|                                  |       |
|----------------------------------|-------|
| More Doctors                     | ***** |
| Male Healthcare Staff            | ****  |
| More contact with family/friends | ***** |
| More exercise                    | ***** |
| A ban on smoking                 | ***** |

**And what about more advise on**

|                           |       |
|---------------------------|-------|
| How to stop smoking       | ***** |
| Sexual and physical abuse | ****  |
| Being a father            | ***   |
| Managing money            | ***   |
| Dealing with anger        | ***** |
| Feeling low/depressed     | ***** |
| Safe Sex                  | **    |

**Anything else?**

- More info on courses (SOTP) to reduce depression
- Invite a triage nurse every Friday to help with problems
- When an appointment is missed a letter could be sent out asking for a reason as to avoid an IEP warning.
- Just because you can buy certain things on canteen form should not stop the doctors or dentist giving you these things themselves.
- Courses needed on behaviour problems and anger issues.
- Just a simple hello by the HCA would be nice
- Don't treat every prisoner with contempt – a shrug and a sigh is not a good way to start a conversation

**Other comments**

- The main health care is really good, just the waiting times are a problem as you can be waiting months.
- Would like a fitness channel and info on how to look after yourself.

- More support for Transgender issues as not enough support, no facilities or clothing for transgender. More support needed for transgender inside prison and outside once left.
- This questionnaire should be given to all
- Longer times to deliver meds in the morning – start earlier or move labour movement

**Age**

The age range of respondents was from age 35 to 56 with an average age of 39.

## 8 DISCUSSION

This study has taken a systematic approach to assessing the health needs of prisoners in the five prisons in Lancashire, utilising a variety of information sources and data. In this section, the findings of the report are discussed. However, before doing so, it is worth considering some of the practical problems/limitations of this report:

Limitations:

- The data being recorded in the prisons is currently of variable quality, with evidence of inconsistent and incomplete recording. This has created some anomalous findings (i.e. use of patient-contacts in measuring health services activity) makes it difficult to draw conclusions.
- The calculated disease prevalence figures in the Epidemiological Needs Assessment are based on relatively old reference data (much of which originates from studies in the 1990s). However, in the absence of good quality local data – the expected prevalence figures are currently the best estimates.
- The expected prevalence figures are based on the current prisoner population structures. Given the national pressures on the prison service to accommodate prisoners, if the population structures were to change significantly in any of the prisoners, then the estimates would need to be revised.
- In the Corporate Needs Assessment – the number of responses from staff and prisoners was small and this may mean that they may not reflect the views of the wider prison populations and may not reflect minority group views e.g. foreign nationals, ethnic minorities, those with disabilities, older prisoners and homosexual prisoners.
- The broad remit of this HNA (i.e. it covered all five prisons and looked at all the healthcare services) has meant that it was not possible to examine/audit



the health services in detail. For the same reason, it has not been possible to undertake any detailed evidence reviews or assess cost-effectiveness of the services.

#### A caution about interpreting statistics

When considering the reasons for any differences in the statistical data the following reasons should always be considered to explain the differences:

**Chance** – this is due to random variation and is particularly important where relatively small numbers are concerned. Therefore, whilst the numbers of asthmatics may be higher in one prison this year, in the following year, this could change, due to chance variations.

**Artefact** – this is where the difference is not real, but the result of how the information is collected. So for example, the higher prevalence of asthmatics in one prison may be due to better recording by health professional of those with asthma.

**Real** – that is, that the prevalence of asthma really is higher in one prison than another. In this example, this is likely to be the case as asthma is commoner in younger adults (i.e. the Farms) than older populations (i.e. Wymott).

QOF does not provide a comprehensive source of data on quality of care in the prisons, but it is potentially a rich and valuable source of such information, providing the limitations of the data are acknowledged.

It is clear that prisoners have poorer health than the general population and that there are marked inequalities amongst the prison population therefore any future planning of the healthcare services within the prisons needs to be based on an understanding of healthcare needs – as apposed to driven by demand (from professionals or prisoners) and historical precedent.

To ensure robust understanding of need requires robust data recording and as all the health care services are now using System One this should support both future health needs assessment and service reviews as well as equity audit.

On the whole, the prison healthcare services in Lancashire provide a good range of clinical services that meet the needs of the prisoners. Some gaps and quality issues exist, and these should be addressed to ensure that the needs of prisoners are met, and to ensure equivalence with healthcare services found in the community, both in terms of quality and the range of services available. Many of these gaps relate to allied health and prevention services.

However, in order to respond to these unmet needs, more effort is needed to reduce the current demand placed on healthcare services through increasing prisoners' ability to self-care and reduce their dependence on formal healthcare services and a focus on a whole prison approach to health and well being.

Whilst the prison environment can have a detrimental effect on an individual's health (e.g. in terms of mental health), they also provide an ideal setting to provide services to a disadvantaged, often socially-isolated group, who may otherwise not access healthcare services. However, a key challenge for the prison health services is not to merely address the physical and mental health needs of prisoners using the traditional medical approach, but to foster a whole prison culture of prevention and education, to ensure that on release, prisoners are better equipped to lead healthier, more informed lives. A large majority of the health problems prevalent in the prison populations are behaviour-related, and require a robust whole prison approach to prevention and behaviour change if long-term health prospects of prisoners are to be improved.

Whilst mental health and substance misuse remain the key health issues within the prisons there is an increasing requirement to consider the increased prevalence of long term conditions. It is clear that the percentage of older prisoners is increasing

and this brings higher rates of many health issues that will require a focus on long term conditions and appropriate environmental adaptations. For those prisons that take both young offenders and adult prisoners there will need to be a balance achieved between the very differing needs of both young and older prisoners.

It is clear from the Corporate Health Needs Assessment that prison health care is valued by the prisoners and that prisoners are provided with a level of health care that is generally in line with that offered in the community however responses regarding improvement appear to focus on process rather than quality and nature of interaction i.e. waiting times and appointment processes.

Most of the prisoners have an understanding of what makes them healthy i.e. access to healthy food, physical activity and stopping smoking and reducing alcohol intake as well as recognition of psychosocial elements of well being e.g. family contact and relationships. This is in line with findings from community based male surveys.

When asked about ability to make changes these were related to improved food and access to the gym and support services for stopping smoking and alcohol and drug misuse along side wanting increased contact with family and friends and having “someone to talk to”.

This health needs assessment has taken a broad view of the health needs of the prisoners however it would be advisable to do further specific service related Health Needs Assessment when commissioning existing or new services.

## 9. RECOMMENDATIONS

The following recommendations are made from the gaps identified between existing provision and the needs identified through the epidemiological, comparative and corporate needs assessments. They also contain recommendations where the health needs assessment was unable to assess the current provision and provision against best practice. They have not been prioritised or costed as this will form part of the action planning process led by the Prison Partnership Board. Where a review of a service is recommended, this could be undertaken as a separate piece of work, or alternatively, could form the basis of more specific HNAs in the future.

| RECOMMENDATIONS:   | HMP Lancaster Farms | HMP Kirkham | HMP Garth | HMP Wymott | HMP Preston |
|--|---------------------|-------------|-----------|------------|-------------|
| <b>General</b>   |                     |             |           |            |             |
| Improve the recording of health and patient data across the five prisons, fully utilising the Systemone database to record all aspects of health care, QOF prevalence's, patient demographic data within each prison to support more robust needs assessment and to allow equity audits to be carried out. | √                   | √           | √         | √          | √           |
| Staff training on the use of the computer system should be provided.   | √                   | √           | √         | √          | √           |
| Administrative support should be reviewed and adequate support provided to ensure full utilisation.  | √                   | √           |           |            |             |

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| A review and standardisation of codes should be undertaken and agreed across all five prisons.  | √ | √ | √ | √ | √ |
| The prison equality leads should help identify any specific health and well being needs/issues of minority prisoners, e.g. foreign nationals, ethnic minorities, those with disabilities, older prisoners and homosexual prisoners. E.g. Support should be provided to prisoners with language or literacy problems to ensure they have access to prison and health services and disability reviews and assessments should be undertaken to ensure disabled prisoners have access to appropriate aids and facilities. | √ | √ | √ | √ | √ |
| The prison service should ensure that an adequate number of first aid trained staff are available at all times  | √ | √ | √ | √ | √ |
| <b>Service Review</b> - A review of the following services should be undertaken to ensure that prisoners have access to appropriate care:   |   |   |   |   |   |
| GUM and sexual health services (all prisons) – review current service provision including access to condom and lubricant provision.   | √ | √ | √ | √ | √ |
| Dental services – access to dental services should be improved by prioritising access according to need, and ensuring a greater preventive service through introducing a system for routine dental examinations, dental triage and treatment. Consideration should be given to extending the dental capacity within the prisons, perhaps using other professionals such as a dental hygienist.  | √ | √ | √ | √ | √ |
| The pharmacy services should be reviewed and provided in line with the national strategy, particularly the integration of pharmacy services into the overall delivery of healthcare services, e.g. medicine management clinics and support for patient self-management.   | √ | √ | √ | √ | √ |
| Drug and alcohol services, including CARAT should be reviewed and consideration given to developing an integrated substance misuse service within Lancashire prisons.   | √ | √ | √ | √ | √ |

| <b>Future Needs Assessment</b>   |   |   |   |   |   |
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| A needs assessment of Allied Health Services, Podiatry, Physiotherapy, Speech and Language Therapy and Occupational Therapy should be undertaken to ensure commissioning of appropriate levels of service equivalent to community provision. | √ | √ | √ | √ | √ |
| Review Lancaster Farms needs assessment in 12 months following changes to current population from re-role.   | √ |   |   |   |   |
| <b>Physical Health</b>   |   |   |   |   |   |
| <b>Health Promotion, Diet, Physical Activity, Smoking,</b>   |   |   |   |   |   |
| An Audit of health promotion activity and plans should be undertaken to provide assurance as to compliance with all elements of PSO3200  | √ | √ | √ | √ | √ |
| A lifestyle screening tool should be used to assess lifestyle behaviours and information recorded on System One to enable appropriate lifestyle and behaviour change programmes to be commissioned commensurate to need.                     | √ | √ | √ | √ | √ |
| A comprehensive whole prison training programme should be provided to build health promotion skills for all staff across the prison. E.g. brief intervention training.   | √ | √ | √ | √ | √ |
| Specialist Stop Smoking Support and appropriate pharmacological products should be provided for all those prisoners who are motivated to quit in line with Department of Health Service guidance.  |   |   | √ | √ | √ |
| Consideration should be given to developing a comprehensive health education and self care approach for prisoners including the use of health champions, peer supporters and health trainers.  | √ | √ | √ | √ | √ |

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| Prison caterers should improve the diet of prisoners, especially those aspects of diet which could adversely affect health, by, for example, reducing the high energy content of some meals taking into account the different requirements of prisoners being catered for (according to age and gender); setting specifications for suppliers to offer healthier products; not offering fried foods too frequently; offering plenty of fruit and vegetables, including more wholegrain products; serving fish regularly including oily fish at least once a week; and increasing dietary fibre. | √ | √ | √ | √ | √ |
| The Prison Service should provide practical guidance and training to all prison caterers on healthy catering practices and nutrition, including standard healthy option recipes, and the correct labelling of healthy food.   | √ | √ | √ | √ | √ |
| The Prison Service should raise the level of awareness of healthy eating among the prison population through educating prisoners on the importance of healthy eating, posters, and by actively promoting it on a regular basis.   | √ | √ | √ | √ | √ |
| Physical Activity programmes, including rehabilitation programmes for older prisoners, those with long term conditions and post cardiac episodes should be reviewed and consideration given to future provision.  |   | √ | √ | √ | √ |
| <b>Long term Conditions</b>   |   |   |   |   |   |
| Registers for Long Term Conditions should be reviewed and updated. (all prisons)  |   | √ | √ | √ | √ |
| Screening and health checks should be provided in line with national guidance and appropriate services for long term conditions commissioned.   | √ | √ | √ | √ | √ |
| Consideration should be given to the development of expert patient programmes within the prisons.   |   | √ | √ | √ | √ |
| <b>Health Protection</b>  |   |   |   |   |   |

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| As of September 2009 a clear schedule exists as devised by the HPA and signed off by the North West Prison's health protection steering group that sets out the required immunisation requirements for prisoners therefore an immunisation service should be commissioned in line with this schedule including MMR, Men C, seasonal influenza, BCG, pneumococcal and Hep B. | √ | √ | √ | √ | √ |
| Service specifications should be modified to ensure that service assessment systems and practice are aligned with this schedule.  | √ | √ | √ | √ | √ |
| In line with the service specification practices should become more consistent across all five prisons.   | √ | √ | √ | √ | √ |
| Clinical staff should have or undergo appropriate training to consolidate knowledge and skills around immunisation and delivery procedures.   | √ | √ | √ | √ | √ |
| All Nurses should have easy access to the "Green Book" in vaccination clinics.  | √ | √ | √ | √ | √ |
| Review of immunisation record keeping and the transfer of this information should be reviewed to ensure prisoners have an up to date record of their immunisation status on transfer/release.   | √ | √ | √ | √ | √ |
| Review of available immunisation advice and information for prisoners should be undertaken to ensure that it is presented in a variety of appropriate ways.   | √ | √ | √ | √ | √ |
| Data collection, recording and reporting systems should be developed in line with record keeping standards.   | √ | √ | √ | √ | √ |
| Review existing screening measures for HIV and Hep C and implement screening programmes in line with Health Protection Agency recommendations.  | √ | √ | √ | √ | √ |
| <b>Mental Health Services</b>   |   |   |   |   |   |



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| Develop a clear blueprint for the delivery of mental health services in prison, including appropriate external support and governance, and internal integration with other prison staff and services.  | ✓ | ✓ | ✓ | ✓ | ✓ |
| In addition to in-reach services, the provision of designated, structured primary care mental health services is essential, including the provision of psychological therapies within primary care and access to self-help programmes.   | ✓ | ✓ | ✓ | ✓ | ✓ |
| Recognise that care and support for those with mental and emotional needs should not be seen as the exclusive province of mental health professionals but requires a holistic approach, as part of a model of a 'healthy prison' – (one where prisoners are safe, treated respectfully, able to engage in purposeful activity, and prepared for resettlement.) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Robust communication/liaison pathways between mental health services and other agencies, including departments within the prison service itself, is also indicated – for example, education, offending behaviour programmes, and drug and alcohol treatment programmes.  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Reception screening appears to be failing to pick up the extent or diversity of need. This is partly because it is not always done by appropriately skilled staff. But it is also partly because the screen itself is not sensitive enough to pick up real, and particularly unacknowledged, need.   | ✓ | ✓ | ✓ | ✓ | ✓ |
| The collation of information regarding all services in the prisons providing mental health care at all levels is needed in order to establish a clear picture of what is currently provided.   | ✓ | ✓ | ✓ | ✓ | ✓ |

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| There is a clear need for a range of mental health staff with expertise in the area of intellectual disability, in order to provide clinical assessment, support for some individuals within the prison, and consultation to other staff.  | √ | √ | √ | √ | √ |
| Clear liaison and referral mechanisms between existing and any new services which are developed.   | √ | √ | √ | √ | √ |
| Prison staff should have access to good quality training in working with people with mental health problems, intellectual disability and personality disorder, to enable them to recognise these conditions and to support those who have them, as well as to enable them to manage such prisoners within the prison environment.  | √ | √ | √ | √ | √ |
| Clearly defined mechanisms for prison staff to access consultation with mental health services within the prison are essential. Training alone is insufficient to bring about a sustained benefit; prison staff need to be able to discuss with mental health practitioners those prisoners they have identified who may need further assessment, or to consult about the management and support of those who are already known to mental health services. | √ | √ | √ | √ | √ |
| For those prisoners who return to the community with mental health needs clearly defined under the Care Programme Approach (CPA) there are pathways to support continuity of care post-release. Liaison with local services and with families/carers may also be indicated for some other prisoners who have identified mental health needs and mechanisms for this should be considered.  | √ | √ | √ | √ | √ |
| <b>Learning Disabilities</b>   |   |   |   |   |   |
| Links should be made with the Learning Disabilities Joint Strategic Needs Assessment.  | √ | √ | √ | √ | √ |

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| Prison partnership Boards should review whole prison approach to the provision of LD care and support in line with the Bradley Report.               | √ | √ | √ | √ | √ |
| <b>Well Being</b>  |   |   |   |   |   |
| Develop social prescribing mechanism in line with community mental health model  | √ | √ | √ | √ | √ |
| Prisons to sign up to Decade of Well-being – Living Well approach – and promote the five ways to well-being  | √ | √ | √ | √ | √ |
| Access to Computerised Cognitive Behavioral Therapy where appropriate should be explored.  | √ | √ | √ | √ | √ |
| Access to Bibliotherapy in partnership with libraries should be explored.  | √ | √ | √ | √ | √ |
| <b>Palliative and End Life care</b>  |   |   |   |   |   |
| Review current approach and formalise current practice on Palliative Care in Lancashire Prisons through the development of a palliative care policy. | √ | √ | √ | √ | √ |

## Appendix 1

### Population and Capacity (Ministry of Justice)<sup>146</sup>

#### Definitions:

1 - The operational capacity of a prison / IRC is the total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime. It is determined by area managers on the basis of operational judgement and experience.

2 - Useable Operational Capacity of the estate is the sum of all establishments' operational capacity less 2,000 places. This is known as the operating margin and reflects the constraints imposed by the need to provide separate accommodation for different classes of prisoner i.e. by sex, age, security category, conviction status, single cell risk assessment and also due to geographical distribution.

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<sup>146</sup> <http://www.justice.gov.uk/downloads/publications/statistics-and-data/hmps/prison-population-22-07-11.doc>

## Appendix 2

### List of Abbreviations

|                      |  |
|----------------------|--|
| <b>AA</b>            | <b>Alcohol Anonymous</b>   |
| <b>ACCT</b>          | <b>Assessment, Care in Custody Teamwork</b>                      |
| <b>A&amp;E</b>       | <b>Accident and Emergency</b>                                    |
| <b>ABI</b>           | <b>Alcohol Brief Intervention</b>                                |
| <b>ADHD</b>          | <b>Attention Deficit Hyperactivity Disorder</b>                  |
| <b>AIDS</b>          | <b>Acquired Immune Deficiency Syndrome</b>                       |
| <b>ASD</b>           | <b>Autistic Spectrum Disorder</b>                                |
| <b>BBV</b>           | <b>Blood Borne Virus</b>   |
| <b>BME</b>           | <b>Black Minority Ethnic</b>                                     |
| <b>BMI</b>           | <b>Body Mass Index</b>   |
| <b>BP</b>            | <b>Blood Pressure</b>  |
| <b>CARATS Scheme</b> | <b>Counselling, Assessment, Referral, Advice and Throughcare</b> |
| <b>CBT</b>           | <b>Cognitive Behavioural Therapy</b>                             |
| <b>CHD</b>           | <b>Coronary Heart Disease</b>                                    |
| <b>CJLT</b>          | <b>Criminal Justice Liaison Team</b>                             |
| <b>CJMHT</b>         | <b>Criminal Justice Mental Health Teams</b>                      |
| <b>COPD</b>          | <b>Chronic Obstructive Airways Disease</b>                       |
| <b>CPA</b>           | <b>Care Programme Approach</b>                                   |
| <b>CVD</b>           | <b>Cardio Vascular Disease</b>                                   |
| <b>DH</b>            | <b>Department of Health</b>                                      |
| <b>DNA</b>           | <b>Did Not Attend</b>  |
| <b>DPH</b>           | <b>Director Public Health</b>                                    |
| <b>EPP</b>           | <b>Expert Patient Programme</b>                                  |
| <b>ETS</b>           | <b>Enhanced Tuberculosis Surveillance System</b>                 |
| <b>FCMHT</b>         | <b>Forensic Community Mental Health Team</b>                     |
| <b>GI</b>            | <b>Gastro-intestinal</b>   |
| <b>GP</b>            | <b>General Practitioner</b>                                      |
| <b>GUM</b>           | <b>Genito-urinary Medicine</b>                                   |

|               |   |
|---------------|---|
| <b>HCV</b>    | <b>Hepatitis C Virus</b>                                    |
| <b>HIV</b>    | <b>Human Immunodeficiency Virus</b>                         |
| <b>HMCIP</b>  | <b>Her Majesty's Chief Inspector Prisons</b>                |
| <b>HMP</b>    | <b>Her Majesty's Prison</b>                                 |
| <b>HNA</b>    | <b>Health Needs Assessment</b>                              |
| <b>IDDM</b>   | <b>Insulin Dependant Diabetes Mellitus</b>                  |
| <b>IDTS</b>   | <b>Integrated Drug Treatment Service</b>                    |
| <b>LCFT</b>   | <b>Lancashire Care NHS Foundation Trust</b>                 |
| <b>LD</b>     | <b>Learning Disability</b>                                  |
| <b>MAPPA</b>  | <b>Multi-agency Public Protection Arrangements</b>          |
| <b>MDO</b>    |   |
| <b>MDT</b>    | <b>Mandatory Drug Testing</b>                               |
| <b>MHIT</b>   | <b>Mental Health In Reach Team</b>                          |
| <b>MHTR</b>   | <b>Mental Health Treatment Requirement</b>                  |
| <b>NHS</b>    | <b>National Health Service</b>                              |
| <b>NICE</b>   | <b>National Institute of Health and Clinical Excellence</b> |
| <b>NIDDM</b>  | <b>Non Insulin Dependant Diabetes Mellitus</b>              |
| <b>NLTPCT</b> | <b>North Lancashire Teaching Primary Care Trust</b>         |
| <b>NOMS</b>   | <b>National Offender Management Service</b>                 |
| <b>ONS</b>    | <b>Office National Statistics</b>                           |
| <b>PASRO</b>  | <b>Prison Addressing Substance Related Offending</b>        |
| <b>PCT</b>    | <b>Primary Care Trust</b>                                   |
| <b>PID</b>    | <b>Pelvic Inflammatory Disease</b>                          |
| <b>PMHT</b>   | <b>Primary Mental Health Team</b>                           |
| <b>PMS</b>    | <b>Primary Medical Service</b>                              |
| <b>PPB</b>    | <b>Prison Partnership Board</b>                             |
| <b>PSI</b>    | <b>Prison Service Instruction</b>                           |
| <b>PSO</b>    | <b>Prison Service Order</b>                                 |
| <b>QOF</b>    | <b>Quality and Outcomes Framework</b>                       |
| <b>RAF</b>    | <b>Royal Air Force</b>                                      |
| <b>RCGP</b>   | <b>Royal College General Practitioners</b>                  |
| <b>SMT</b>    | <b>Senior Management Team</b>                               |
| <b>STI</b>    | <b>Sexually Transmitted Infection</b>                       |
| <b>TB</b>     | <b>Tuberculosis</b>   |
| <b>UK</b>     | <b>United Kingdom</b>                                       |
| <b>VTC</b>    | <b>Vocational Training Centre</b>                           |

|            |                                   |
|------------|-----------------------------------|
| <b>WHO</b> | <b>World Health Organisation</b>  |
| <b>YOI</b> | <b>Young Offender Institution</b> |