Executive Summary

This document has been produced to identify the health needs of prisoners in HMP Wormwood Scrubs so that appropriate and effective services can be commissioned for the prison population.

It is split into 8 main sections - Prison Demographics, Reception of Prisoners, Epidemiology of Prison Health, Vulnerable Groups, Provision of Health Services, Review of Best Practice (effective services, interventions, and guidelines), Service User Views, Corporate Views – and uses mixed methods including data analysis from local systems, performance reporting, benchmarking to national literature and focus groups to deliver recommendations on page 4.

The Prison Population

HMP Wormwood Scrubs is a local Category B closed prison, which accepts all suitable male prisoners over the age of 21 from the courts in the West London, North-West London, and parts of Central London catchment areas. The current operational capacity of the prison is 1,281.

HMP Wormwood Scrubs has a high turnover of prisoners, with most only in custody for a short period of time - the HMCIP inspection in 2011 reported that the modal length of stay for sentenced prisoners at HMP Wormwood Scrubs was between 1 and 3 months. Only 9.7% of sentenced prisoners had currently served longer than 6 months.

The high turnover of the prison population presents a significant challenge to the organisation of health services, particularly with respect to chronic disease management, education and drug rehabilitation programmes.

In addition, prisoners serving short sentences suffer multiple social disadvantages and are a diverse group encompassing a wide range of ages and ethnicities. They have a series of health needs while in custody and significant issues on release (especially for accommodation). The chances of re-offending are high.

The Prison Health Need

This document highlights the current range of services that are available for prisoners in HMP Wormwood Scrubs. These include primary and secondary care services for both physical and mental health.

Local data accessed indicates that the actual numbers of prisoners diagnosed with specific health conditions (including Asthma, Diabetes, Epilepsy and Learning Disabilities) is above that of the local population in the adjacent areas in the local community.

However, the rates picked up are below estimated prevalence figures highlighted in national research projects. This may indicate that health conditions are not being picked up at reception and may lead to health and health concerns worsening while in prison.

In addition, there are higher levels of mental health disorder, smoking, and worse dental health than in the general population.

A separate specific Needs Assessment has been completed on Substance Misuse within HMP Wormwood Scrubs. It is therefore not included is great detail in this document.

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Senior Public Health Intelligence Analyst
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**Recommendations**

**Overarching principle for healthcare delivery**

Prisoners should be cared for by a health service that comprehensively 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.

**Recommendations**

- Introduction of effective communication protocols and action plans between healthcare providers, specialist services and prison staff to ensure clinic DNA rates reduce. Healthcare providers to ensure continued implementation of the induction scheme. Scheme will also look at implementing a reserve list of patients.

- The healthcare provider to ensure the induction procedure focuses on identifying on-going health issues amongst the prison population.

- The healthcare providers to ensure all staff are well equipped through appropriate training to guarantee robust data recording and data management from the existing clinical systems. Good data recording will show an increase in the accuracy of data collection, the creation of historical disease / condition registers (including multiple prescribing and comorbidity), and the planning of regular interrogation of intelligence data on patterns of service use and epidemiology within the prison to inform service delivery.

- The healthcare providers to introduce the concept of active self-management to prisoners through modular or incremental health and learning programmes to enable short-term prisoners to engage in easily replicable techniques for managing their own healthcare issues. This has potential to improve the health inequalities seen in the offender cohort for the future.

- The healthcare provider to ensure the investment in the X-ray room can reap on-going and broad health benefits for TB monitoring and minor injuries (fractures and MSK issues).

- Healthcare services in HMP Wormwood Scrubs will conduct regular assessment and analysis of prisoner health needs and service trends and comparisons in the future in light of the prevailing changes in the wider healthcare landscape. This assessment and analysis will be done in partnership with the prison establishment staff, commissioner and other stakeholders as required.

- To build stronger links with the education department in order to provide health promotion material to a wider audience, capitalising on the capability of the education department to reach more prisoners.
HMP Wormwood Scrubs is a local Category B closed prison, which accepts all suitable male prisoners over the age of 21 from the courts in the West London, North-West London, and parts of Central London catchment areas. The current operational capacity of the prison is 1,281.

Although the actual numbers of prisoners fluctuate slightly from day to day, prisoner numbers are mostly at operational capacity levels.

The establishment has five main wings plus a number of smaller dedicated units:-

- A and B wing manage both remand and sentenced prisoners
- C wing manages prisoners on the Intensive Drug Treatment System (IDTS) which offers enhanced support for offenders with substance misuse needs.
- D wing has single cell accommodation which caters for those prisoners who are the main workforce for areas such as Kitchens, Gardens and ground cleaning. The wing is also staffed for the Difficult to Manage Programme prisoners and those unable to share accommodation.
- E wing is single cell accommodation whose purpose is primarily for the resettlement of prisoners back into the local area.
- The Conibeere Unit manages prisoners who require a substance misuse stabilisation regime. A super enhanced wing is now fully operational and manages those prisoners considered to be trustworthy and who have key roles within the establishment either as key workers or who provide peer support for areas such as the Samaritans or educational support programmes.

The prisoners housed at HMP Wormwood Scrubs broadly fall into three categories:-

- Remand prisoners and those on shorter sentences.
- Foreign Nationals
- Resettlement inmates returning to London to serve the last 6-9 months of their sentence.

The prison has a very high turnover of prisoners, with throughput of prisoners estimated at 400-500 new prisoners per month. This fact presents significant challenges to the organisation of health services, particularly with respect to chronic disease management, education and drug rehabilitation programmes.

The prison is not intended to house large populations of ‘lifers’ or those on long sentences.
The latest HMCIP inspection report (June 2011) shows the prison population at HMP Wormwood Scrubs to be 1,266. This is 98.8% of the prison’s operational capacity of 1,281.

**Sentence**

HMP Wormwood Scrubs largely houses prisoners on remand or short term sentences.

Chart 1 shows the 50.24% of prisoners were sentenced, while 49.76% were classed as not sentenced.

At the last HMCIP report, there were 560 unsentenced prisoners with a further 238 serving a term of less than 12 months (see chart 2). This indicates that the prison operates with a significant turnover of inmates (turnover of population at HMP Wormwood Scrubs is approximately every 10 weeks) and hence creates a significant challenge for the provision of healthcare in this environment.

Chart 2 also identifies that there are particularly few long term prisoners at HMP Wormwood Scrubs - 147 prisoners serving between 4-10 years, 9 serving greater than 10 years, and 26 prisoners serving life sentences at the time of review.
In recent years, the trend for many remand prisoners facing a long term in prison has been that they are transferred to another institution once convicted and sentenced. This is reflected in the proportion of long term prisoners which has been stable since 2008, but is a notable decrease on the period 2003-2008.

The HMCIP inspection (2011)\(^1\) reported that the modal length of stay for sentenced prisoners at HMP Wormwood Scrubs was between 1 and 3 months. Only 9.7% of sentenced prisoners had currently served longer than 6 months. The modal length of stay was less than 1 month for unsentenced prisoners; however 13.2% of unsentenced prisoners had served longer than 6 months. At the time there was only 1 inmate at HMP Wormwood Scrubs who had been imprisoned for longer than 4 years.

**Security Category**

Chart 3 shows the majority of prisoners (611) were categorised as security Category C (48.26%), 50 prisoners (3.95%) were Category D and 30 were Category B (2.37%). 555 prisoners (43.85%) were unclassified, and a further 20 prisoners (1.58%) were specified as other (Uncategorised, Unsentenced or YOI Closed). This highlights that the prison is currently housing a majority of prisoners below the security capacity it was built for.

![Security Category Chart](chart3.png)

**Age**

HMP Wormwood Scrubs has a particularly young population, with an average age of 34.45 years.

![Age Chart](chart4.png)

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72.83% of the population seen at prison reception in the last 12 months were under the age of 39, while only 8.39% were over the age of 50. Chart 4 below shows a breakdown of the current prison population by age group.

**Ethnicity**

The prison houses a high proportion of inmates from minority ethnic groups, although the exact proportions vary slightly over time. Data from prisoners seen at reception in the last 12 months identifies that the majority of prisoners admitted were from a minority ethnic group.

42.27% of admitted prisoners in the last 12 months classed themselves as of White origin, 21.19% as Mixed, 19.85% as Black or Black British, 15.96% as Asian or Asian British, 0.24% as Chinese, and 0.49% as Other. This data demonstrates that HMP Wormwood Scrubs holds a much larger minority ethnic community compared to the catchment areas of the prison.

**Religion**

According to the HMCIP survey (2011), the majority of prisoners (50.08%) professed a Christian faith, however as demonstrated in Chart 7, there are significant numbers of other faiths in HMP Wormwood Scrubs, and the largest proportion of these are Muslim (20.77%). A significant minority stated that they professed no religion (11.30%).
Nationality & Language

HMP Wormwood Scrubs has a significant foreign national population. The actual proportion fluctuates considerably, however, the HMCIP inspection in June 2011 found that 452 of the 1,266 prisoners were foreign nationals; this represents 35.7% of the prison population.

Prisoners came from a large number of different countries - the largest being Poland, Romania, India, Somalia and the Arab states. In a 2011 survey, 27% of prisoners did not speak English as their first language (LISAR\(^2\)).

However, the majority of those who did not speak English as a first language did speak enough English to enable effective communication. Consequently, only a small minority of all prisoners (6%) required interpreting (LISAR, 2011).

Borough of Residence

The table below shows the resident borough of prisoners sent to HMP Wormwood Scrubs in 2011. Approximately 80% of prisoners come from the nearest 10 boroughs in London, with over a third residing in the three nearest boroughs - Hammersmith & Fulham, Ealing and Brent.

![Chart 7 - Local Borough of Residence of HMP Wormwood Scrubs prisoners prior coming to prison, HMCIP Report (2011)](image)

<table>
<thead>
<tr>
<th>Borough</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Brent</td>
<td>6.7%</td>
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<tr>
<td>Ealing</td>
<td>10.5%</td>
</tr>
<tr>
<td>Harrow</td>
<td>11.8%</td>
</tr>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>14.0%</td>
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<tr>
<td>Hounslow</td>
<td>7.1%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>9.7%</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea</td>
<td>11.2%</td>
</tr>
<tr>
<td>Westminster</td>
<td>2.5%</td>
</tr>
<tr>
<td>Camden</td>
<td>2.5%</td>
</tr>
<tr>
<td>Other</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

Accommodation Status

According to LISAR responses during 2011, a comparatively large proportion of prisoners were without fixed abode prior to coming into prison (22%), however only 6 prisoners, >1% of all prisoners, lived on the streets prior to coming to prison. A further 17% of prisoners stated that they lived in temporary accommodation prior to prison.

Overall 41% of the prisoners responding could be classed as in accommodation need. 20% of prisoners said they were in receipt of housing benefit prior to being in prison.

\(^2\) The primary purpose of LISAR is to screen prisoners upon their reception into London prisons, to identify their needs and make appropriate referrals. In addition to this, LISAR serves as a data source, covering receptions into London prisons. There are some important limitations to bear in mind when interpreting LISAR data:

- LISAR relies on self-reporting, so caution should be applied.
- Some offenders will be received into a London prison more than once throughout the year and as such there may be two or more LISAR records which refer to the same offender.
- There are some prisoners for whom there is not a fully completed LISAR interview.

A full list of caveats can be found on the Ministry of Justice website.
Employment & Income Status

In terms of employment, 43% of prisoners identified as unemployed before coming into prison, 24% said they were employed full time, 5% said they were employed part time, 4% said they were self employed full time, and 4% said they were in full time education.

38% of prisoners said their main source of income prior to prison was from benefits, 33% said employment, 4% said crime and 1% said savings. A large proportion of prisoners responded with ‘Other’ which includes supply of income from family and friends and other informal networks.

Gender

HMP Wormwood Scrubs is a male only prison.
HMP Wormwood Scrubs takes prisoners from a relatively wide area; but the majority of prisoners come from courts in Central and North West London. Prisoners are admitted as new to jail, transferred from another institution, or returned from court. All prisoners must be received in reception, transferred to a waiting cell for a health assessment and then on to the First Night Centre where their first night is spent in an inductive and supported environment before moving to the wings.

Receptions and transfers occur Monday to Saturday in the Prison Reception and First Night Centre.

The initial health screen should be completed for all new prisoners within 24 hours, before the first night of sleep for the prisoner.

This initial assessment includes a thorough standardised health care screening to identify any immediate health or safety risk, and to identify any new or on-going healthcare needs. Prisoner’s health needs are often complex, and it is important that prisoners’ needs with respect to their mental health, potential drug and alcohol problems, and their pressing physical needs are diagnosed and addressed at this early stage in order to avoid morbidity or mortality in prison. Further Screening for Sexual Health, TB and detailed Substance Misuse occur within 72 hours.

This screening process usually takes place at reception and timely assessment is fundamental to ensure the health and safety of individual prisoners.

In the morning reception focuses on prisoners going out to court / transfers / release.

In the afternoon prisoners are received in from court or transfers. Reception of prisoners hence usually takes place between 13:30 and 21:00 hours and this time can only be extended in exceptional circumstances. This is not least due to prisoner lock-down at 22:00 hours. It is of note that the majority of prisoners arrive after 17:00 hours.

However, the current shift pattern of staff working on reception does not necessarily align with the time of these processes.

The day shift on reception is between 07:45 to 19:45 and there is usually 1 qualified nurse in reception and 1 Health Care Assistant and 2 qualified nurses in the First Night Centre.

The night shift on reception and the First Night Centre is 19:45 to 07:45 and is staffed by 2 qualified nurses who provide emergency cover throughout prison during the shift, and prepare transfer paperwork for next day, in addition to providing health screens.

The relatively small staff capacity at reception can often mean a waiting time (initial health screens can take until 2-3am to be completed), during which the prisoner is held in a waiting cell with many other prisoners. The diagram below shows the route of a prisoner and the indicators recorded from reception at HMP Wormwood Scrubs.
The diagram below shows the route of a prisoner and the indicators recorded from reception at HMP Wormwood Scrubs.

Diagram 1 - Prisoner Route upon arrival at reception at HMP Wormwood Scrubs

**Number of prisoners screened at Reception**

There is an extremely high turnover of prisoners within HMP Wormwood Scrubs. The number of new prisoners per month ranges between 27% and 54% of the total prison population, and the number of prisoners being transferred from other institutes ranges between 6.5% and 14% of the total prison population each month. This turnover creates multiple issues with regards to responding to the complex health needs of prisoners and offering continuity of care. It is therefore highly important that prisoners are health screened at reception and any major health issues are identified early.

Due to the extremely high number of prisoners coming through each day, it is understandable that the healthcare information collected at reception is limited and focused on key issues relating to the immediate need of the prisoners. However, high quality recording of long-term conditions is encouraged so staff can effectively follow-up those prisoners with an on-going health issue and provide them with all the best information on managing a healthy lifestyle.

**New Prisoners**

Between September 2010 and August 2012, 12,907 new prisoners were admitted into HMP Wormwood Scrubs, this equates to an average of approx. 18 new receptions per day. During this period, the most prisoners were admitted in August 2011, where 686 new receptions were carried out. September 2010 saw the fewest new receptions with only 381 carried out that month.

The graph below show the trend in the number of new receptions per month between September 2010 and August 2012. Across this period we can see that the number of new receptions has been steadily rising to a
peak in August 2011 and levelling off since. However, numbers have again risen significantly in July and August 2012. As the prison frequently operates near capacity, some fluctuation month on month is expected dependant on the length of custody of those currently serving. However, the graph indicates that between a third and half of the prison population is ‘new’ to HMP Wormwood Scrubs each month.

![Chart 10 - Number of new receptions per month](image)

Between September 2010 and August 2012, all but 18 new prisoners had an initial risk assessment completed on the day of reception. All 18 prisoners missed were in February 2011, this is likely to have been caused by a localised issue, potentially just on one day. During this time all new prisoners seen at reception were screened for substance misuse issues and TB within 72 hours of reception. Since April 2011, all prisoners have also been screened for problem drinking in addition to standard reception screening.

Once new prisoners have been screened at reception, they are transferred to the First Night Centre where their first night is spent in an inductive and supported environment.

**Transferred Prisoners**

HMP Wormwood Scrubs also receives prisoners transferred from other institutions at reception. The graph below show the trend in the number of prisoners transferred to HMP Wormwood Scrubs per month between September 2010 and August 2012.

In total, 2,555 prisoners were transferred into the prison during this time period, which equates to an average of 106 prisoners per month. Across this period we can see that the number of prisoners transferred in to HMP Wormwood Scrubs has declined from a peak of 176 in September 2010, to 109 in August 2012.
Since the beginning of the 2011/12 financial year in April 2011, an average of 39% of prisoners transferred in from another institution had an initial risk assessment completed on day of reception. This varied between 31% in April 2011 and 47% in August 2011. HMP Wormwood Scrubs is therefore currently falling way behind its target of 100% in this area.

There is currently no data available regarding whether transferred prisoners are separately screened for TB, substance misuse, or dependent alcoholism. However, in most cases, critical information regarding health needs should have been passed on from the sending institution.

Once transferred prisoners have been screened at reception, they are transferred to the First Night Centre where their first night is spent in an inductive and supported environment.
This section will consider the epidemiology of disease within HMP Wormwood Scrubs and prisons in general in the United Kingdom.

The previous Prison Health Needs Assessments (2008) highlighted that the HMP Wormwood Scrubs population has a complex and wide ranging health need. This chapter will attempt to synthesise and update information from the last assessment with the most available data around a number of the most prevalent conditions appearing, and identify current need where possible.

Data will be used from a number of sources, however, data is still limited in this area, so figures must be interpreted with caution.

Local data presented has been extracted from prison healthcare systems and is subject to a number of caveats that are likely to underestimate prevalence including: a lack of correct and consistent coding of diseases by healthcare professionals, incomplete coding, a lack of disclosure from prisoners, and a high ratio of inapplicability arising from the high turnover of prisoners.

Expected disease prevalence in the prison has been estimated using baseline data from the book: Health Care Needs Assessment (2006), Where further prevalence estimates have been used, there source has been noted in the text.

Comparative data from the local community has been extracted from local GP systems for registered patients in Hammersmith & Fulham.

**Minor Illness**

Minor illness is used to describe self-limiting conditions such as skin conditions, 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.

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

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

Minor illnesses amongst prisoners are generally thought to mirror the prevalence in the general population.

Local data shows that the majority of GP consultations in prison concern minor illnesses and the prescription of low-level painkillers.

**Long-Term Illness**

Conversely, long-term illnesses have been found to be more common in prisons compared to the general population nationally.

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1 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](http://www.hcna.bham.ac.uk/chapters.shtml)
The first national survey of the physical health and health-related behaviour of prisoners in England and Wales was conducted by Bridgwood and Malbon in 1994\textsuperscript{4}, and has been used extensively to inform planning and healthcare needs of all prisoners.

This survey found that major illnesses in many organ systems (such as Asthma, COPD, Diabetes, Eczema, CVD) were much more common in prisoners compared with the general population. The table below shows a comparison of the physical health of prisoners with the general population as collected in this survey.

While a similar wide ranging survey has yet to be conducted, it is widely believed that the disparity between prison prevalence rates and the general population has grown over time, particularly amongst the most vulnerable groups.

For example, a substantial proportion (39\%) of young prisoners surveyed nationally reported that they had a long-standing illness or a disability (Harris et al, 2007\textsuperscript{5}). About 15\% reported having respiratory problems (approximately double the prevalence rate observed in the community) and 15\% reported musculoskeletal and mobility problems.

In addition, 83\% of older male prisoners reported a longstanding illness or disability, significantly higher figures than found in equivalent studies of younger inmates and community-based elderly men (65\%) (Fazel et al, 2001\textsuperscript{6})

Regardless of condition, what these studies highlight is that the prison population has a complex and wide ranging health need regarding long-term illness that it needs to tackle.

\begin{table} 
\centering 
\caption{Comparison of the physical health of prisoners with the general population (Bridgwood & Malbon, 1994)} 
\begin{tabular}{|l|c|c|} 
\hline 
 & Prison Prevalence (%) & Popln. Prevalence (%) \\
\hline 
Digestive System & 5 & 3 \\
Musculoskeletal & 16 & 12 \\
Nervous System & 5 & 3 \\
Respiratory & 15 & 8 \\
Skin Complaints & 3 & 1 \\
\hline 
\end{tabular} 
\end{table} 

\textsuperscript{5} Harris, F. et al (2007). Health needs of prisoners in England and Wales: the implications for prison healthcare of gender, age and ethnicity. Health Social Care in the Community, 15:56-66
National data indicates that the prevalence of respiratory conditions in prison is almost double the prevalence in the community (15% vs. 8%, see table 1). The most prevalent respiratory conditions nationally were Asthma and COPD (due to heavy smoking, a young population and poor physical conditioning).

### Asthma

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<thead>
<tr>
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<th>Expected Prison Prevalence</th>
<th>Recorded Prison Prevalence</th>
<th>Community Prevalence</th>
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<tbody>
<tr>
<td></td>
<td>15%</td>
<td>9.2%</td>
<td>8.5%</td>
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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.

Local data from reception screening at HMP Wormwood Scrubs indicates that 8.9% of prisoners are recorded as having Asthma at their initial health screen (equivalent to 114 prisoners at any one time). It is expected that this prevalence rate is an under recording of the ‘actual’ prevalence rate within the prison (estimated at 15%, equivalent to 192 prisoners) for reasons including poor clinical coding, an unwillingness of prisoners to disclose health need (for example, due to long waiting times, or mistrust of authority), a necessity to focus upon just the most severe conditions at reception screening, and a difficulty in diagnosing Asthma specifically in adults.

In addition to reception data, information provided from local primary care systems shows that 240 prisoners were recorded as being diagnosed with Asthma within a year (2011/12) after attending a Primary Care visit. Taking into account the turnover of patients within the prison, this is equivalent to a prevalence of approximately 9.2%. This level of prevalence is subject to the same caveats as above, and the fact that only a specific cohort of prisoners will be able to interact with prison healthcare long enough to receive a diagnosis.

As such, we can state that the locally recorded prevalence figure in HMP Wormwood Scrubs is still higher than the prevalence rate of the general public in Hammersmith & Fulham (the borough HMP Wormwood Scrubs is in) at 8.5%.

It is believed that Asthma is so prevalent within prisons because of two reasons. Firstly, it is widely known that exposure to tobacco smoke either through active smoking or by second-hand smoke can cause and/or exacerbate an asthma attack or asthma symptoms. With smoking prevalence in prisons nationally estimated at 81%, it is expected that the knock-on effects on respiratory conditions are high. Additionally, people with asthma who smoke and continue to smoke have worse symptoms and experience more rapid decline in pulmonary function than those who have asthma but do not smoke.

The second is related to social deprivation. Many studies have shown evidence of greater symptom prevalence of Asthma or reduced lung function in individuals from lower socioeconomic status groups prolonging into adulthood (something reflected in the general population of Hammersmith & Fulham), likewise many studies have shown that the likelihood of entering prison is closely linked with low socioeconomic status.

While there is little research done to date linking the prevalence of Asthma in communities and the likelihood of going to prison, it is logical to suggest that asthma prevalence in HMP Wormwood Scrubs is in part high because of the overrepresentation of individuals from low socioeconomic groups.
COPD

**Expected Prison Prevalence** - 2-4%
**Recorded Prison Prevalence** - 0.4%
**Community Prevalence** - 1.04%

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

Prevalence of COPD in the general population of Hammersmith & Fulham is estimated at approx. 1.04%. Nationally, it is believed that prevalence of COPD is between 2 and 4%.

Local data from reception screening at HMP Wormwood Scrubs indicates that approx. 0.3% of prisoners are recorded as having COPD at their initial health screen. Again, it is expected that this prevalence rate is an under recording of the ‘actual’ prevalence rate, and prison prevalence is likely to be much higher (expected to be approx. 3% for prisoners, equivalent to 38 prisoners at any one time), as up to 80% of prisoners smoke and COPD is present in 18% of male smokers in the UK.

In addition to reception data, information provided from local primary care systems shows that 11 prisoners were recorded as being diagnosed with COPD within a year (2011/12) after attending a Primary Care visit. Taking into account the turnover of patients within the prison, this is equivalent to a prevalence of approximately 0.4%. While this data is subject to many caveats, it is feared that COPD is being under-diagnosed in HMP Wormwood Scrubs.

However, with an expected prevalence of 3% in HMP Wormwood Scrubs, it is widely believed incidence of COPD is occurring amongst younger prisoners at a far higher rate than that of the respective age group in the general population, given the fact that symptoms usually develop in those aged 50+.
Long-Term Conditions

Diabetes

<table>
<thead>
<tr>
<th>Expected Prison Prevalence</th>
<th>-</th>
<th>up to 8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recorded Prison Prevalence</td>
<td>-</td>
<td>4.0%</td>
</tr>
<tr>
<td>Community Prevalence</td>
<td>-</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Age adjusted prevalence of Diabetes in Hammersmith & Fulham is approx. 3.4%. The national prevalence of diabetes amongst the 17+ population is 5.4% (QOF, 2011). Local data from reception screening at HMP Wormwood Scrubs indicates that 121 prisoners have been identified as suffering from Diabetes at their initial screen in the last 12 months. This is indicative of a prevalence rate of 4.01%. Again, this prevalence rate is expected to be an under recording for the variety of reasons mentioned earlier.

Similar to Asthma, Diabetes is strongly linked with socioeconomic deprivation and poor diet in London, so it is expected that prevalence rates will be higher than national rates in HMP Wormwood Scrubs.

Studies carried out in a male prison found that up to 8% of the population were diabetic and could imply that diabetes rates in prison are two times that of the general population (Marshall et al, 1999). As such, a low estimate of the amount of Diabetics expected in HMP Wormwood Scrubs would be 89 prisoners at any one time.

Epilepsy

<table>
<thead>
<tr>
<th>Expected Prison Prevalence</th>
<th>-</th>
<th>0.75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recorded Prison Prevalence</td>
<td>-</td>
<td>1.6%</td>
</tr>
<tr>
<td>Community Prevalence</td>
<td>-</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

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 1,000 population. Prevalence of Epilepsy in the general population of Hammersmith & Fulham is in line with national estimates at 0.8%. However, local data from reception screening at HMP Wormwood Scrubs indicates that approx. 1.6% of prisoners are recorded as having Epilepsy at their initial health screen (equivalent to 22 prisoners at any one time).

The high prevalence of epilepsy does seem to be a prison concern nationally. In male prisoners nationally, 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.

With the prevalence rate of epilepsy in HMP Wormwood Scrubs double that of the general population surrounding the prison, it does seem to be of concern for more research. Early indications suggest the actual rate may be lower in HMP Wormwood Scrubs and the high self-reporting of Epilepsy by prisoners may be related to an attempt to acquire Benzodiazepines.

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Cardiovascular Disease

Expected Prison Prevalence - 0.7%
Recorded Prison Prevalence - n/a
Community Prevalence - 0.5%

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. 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).

Taking these risk factors into account, it is very likely that the high prevalence of smoking and poor socioeconomic circumstances prior to coming to prison will lead to an increased prevalence in HMP Wormwood Scrubs. It is expected that overall prevalence for CVD is 0.7% in HMP Wormwood Scrubs, compared to 0.5% in the general population.

Cancer

Expected Prison Prevalence - n/a
Recorded Prison Prevalence - n/a
Community Prevalence - 1.4%

The national prevalence of cancer is 1.4% (QOF, 2011). Prostate cancer is the most common amongst men, and the second most common cause of cancer-related deaths in men in the UK.

There is very little published on the subject of cancer amongst prisoners and local data on cancer within HMP Wormwood Scrubs is not available. 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.

Learning Disabilities

Expected Prison Prevalence - 2%
Recorded Prison Prevalence - 3%
Community Prevalence - 2.4%

No agreed levels of the prevalence of Learning Disabilities within prisons are evident. While the Department of Health in England and Wales (1998) estimates that 2% of people in the general population have a learning disability, researchers disagree whether this rate is any higher in populations of offenders.

Estimates of prevalence amongst offenders range from 0% - 85%, depending on the assessment tools used, the stage in the criminal justice process at which learning disability is assessed, whether assessments are conducted individually or in groups, the level of training of the people administering the assessments, and variations in policies for diversion. Average estimates of prevalence of learning disability amongst offenders in the UK range from 1 - 10%.

Local data from reception screening at HMP Wormwood Scrubs indicates that approx. 2.4% of prisoners are recorded as having a Learning Disability at their initial health screen (equivalent to 18 prisoners at any

one time). The reception data is supported by data on diagnosis provided from Primary Care visits, which suggests prevalence at any one time in HMP Wormwood Scrubs is equal to 3.08%.

Both of these rates are higher than the equivalent rate in the population locally, and indicates that the high prevalence of inmates with learning difficulties is a significant challenge for HMP Wormwood Scrubs.
The Bradley Report (2009) 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 as custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide.

Despite the introduction in recent years of trained healthcare professionals, the transfer of healthcare provision to the National Health Service, and the indirect better understanding of mental illness amongst prison staff, there still appear to be sizeable gaps in the provision for high mental health need in prisons.

The table below estimates the expected prevalence of Mental Health conditions and the expected number of prisoners this is equivalent to at any one time in HMP Wormwood Scrubs.

<table>
<thead>
<tr>
<th>Mental Health Disorder</th>
<th>Estimated Prevalence (%)</th>
<th>Equivalent No. of Prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality Disorder</td>
<td>64</td>
<td>820</td>
</tr>
<tr>
<td>Functional Psychoses</td>
<td>7</td>
<td>90</td>
</tr>
<tr>
<td>Sleep Disorder</td>
<td>54</td>
<td>692</td>
</tr>
<tr>
<td>Somatic Symptoms</td>
<td>16</td>
<td>205</td>
</tr>
<tr>
<td>Physical Health Worries</td>
<td>16</td>
<td>205</td>
</tr>
<tr>
<td>PTSD</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>Mixed Anxiety &amp; Depression</td>
<td>19</td>
<td>243</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>8</td>
<td>102</td>
</tr>
<tr>
<td>Depressive Episode</td>
<td>8</td>
<td>102</td>
</tr>
<tr>
<td>Phobias</td>
<td>6</td>
<td>77</td>
</tr>
<tr>
<td>OCD</td>
<td>7</td>
<td>90</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td><strong>Any Neurotic Disorder</strong></td>
<td><strong>40</strong></td>
<td><strong>512</strong></td>
</tr>
</tbody>
</table>

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. Clinical mental health 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.

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

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Suicide & Self-Harm

There are also significant issues regarding suicide and self-harm in prisons. Local data suggests that 3.49% of new prisoners screened at reception are identified with serious and immediate mental health risks. This is similar to the expected national prevalence of 4% within prisons. See Table 3, below.

Prevalence of mental health conditions in prison are far higher than compared to the local community, and are estimated to be the single highest cause of ill health within prisons. Tackling the poor mental health of prisoners is a national priority, both for their term in prison and their release to the wider community.

Table 3 - Estimated prevalence of suicidal thoughts / self-harm in adult male prisoners
(Health Care Needs Assessment, 2006)

<table>
<thead>
<tr>
<th>Estimated Prevalence (%)</th>
<th>Equivalent No. of Prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal Thoughts (past week)</td>
<td>4</td>
</tr>
<tr>
<td>Non-Suicidal Self-Harm</td>
<td>7</td>
</tr>
</tbody>
</table>

(Health Care Needs Assessment, 2006)
A substance misuse JSNA was recently carried out in HMP Wormwood Scrubs. Some of the key findings of that report were as follows:

- On average the Conibeere Unit saw 128 prisoners a month, which includes opioid and alcohol users requiring stabilisation (average between Jan 11 and Oct 11). Approximately 56% of all clients coming into the Conibeere unit received a methadone prescription.

- In terms of offences of those prisoners passing through Conibeere, theft and handling offences have the highest occurrence. 44% of heroin and crack users are in prison for a theft and handling offence. 45% of heroin and methadone users are in prison for theft and handling. It is the same amount for heroin and cocaine users. 26% of those prisoners that use alcohol only are in prison for ‘other offences’, 19% are in for theft and handling, 17% are in for violence against the person.

- Between April 2011 and November 2011, 914 prisoners were identified as a substance misuse requiring treatment according to DIRWeb. That is the equivalent of 115 prisoners a month. In 2010/11 the figure was 112 a month and in 2009/10 the figure was 131 a month.

- A large majority of substance misusers are characterised as being aged between 25-34 and White British. The make-up of the substance misusing population differs slightly from that of the general prison population. For example there are proportionally less 21-24 year olds in treatment compared to the numbers in the prison. Also there are proportionally more Asian and White ethnic groups identified as substance misusers.

- Interestingly there are also differences between the permanent residence of the substance misusing population and the general population: the London boroughs of Ealing and Hounslow are over represented, while Hammersmith & Fulham is under represented in the substance misusing population.

- Only half of prisoners that identified as a problem drug user said that they had seen a DIP worker prior to prison.

- The proportion with Heroin as a primary drug type has fallen by 5% from 50% to 45% between 2009 and 2011. Proportions of crack users are constant at 2010 levels after a large increase from 2009.

- Nearly 17% of all random drug tests carried out resulted in a positive test. Out of the population of 1,244 prisoners this is equivalent to 208 prisoners that could test positive at any one time. THC is the most common substance prisoners are testing positive for.

- There are data gaps around multiple prescribing. It is not possible to ascertain if a prisoner is prescribed for more than one substance (e.g. alcohol and opiates). 2011 data indicates that 30% were given first night prescribing for alcohol and 69.6% were given first night prescribing for opiates.

- Just under a third (30.8%) of prisoners underwent alcohol detoxification. 11.3% of prisoners were receiving methadone maintenance and alcohol detoxification.

- According to the answers LISARRT questionnaires 23% of inmates drink at least 6 units on a typical drinking day. This is the equivalent of around 90 prisoners a month entering prison with at least an increasing risk drinking problem. There are approximately 55 prisoners a month with dependent drinking problems. In 2010 the figure was 40 prisoners per month. This includes prisoners with multiple drug problems, including those receiving a substitute prescription.
The prevalence of infectious communicable diseases (particularly HIV and AIDS, hepatitis and tuberculosis) is often much higher in prisons than outside, often related to injecting drug use, MSM and other lifestyle behaviours.

**Sexual Health**

There are no direct estimates of prevalence of sexually transmitted infections (excluding Hep B, C and HIV / AIDS) in the UK prison population however there are some studies with rates of newly diagnosed STIs.

The incidence of sexually transmitted disease has continued to increase in the UK over the past decade, particularly among young people. With regards to risk factors for STIs, 55% of those under 24 in prisons are expected to have unprotected sex in the past year with two or more partners. Prisoners are therefore likely to have a higher incidence of these infections than the wider population.

All prisoners under 24 are routinely offered a urine screen for Chlamydia in HMP Wormwood Scrubs. Since April 2011, 124 prisoners of 1,133 admitted to the prison in this age group have undertaken the test, approx. 12% of prisoners. This level of uptake is fairly low and may be to do with an unwillingness of prisoners to disclose health need, the transitory nature of prison life in HMP Wormwood Scrubs, or personal / cultural issues. Many STIs remain undiagnosed and untreated.

Diagnosis rates are particularly low from the cohort who are willing to provide a sample.

**Blood Borne Viruses (Hep B, HCV, HIV / AIDS)**

In sentenced prisoners, the prevalence of Hepatitis B and C is estimated to be 8% and 9%, respectively. That is equivalent of 102 prisoners with HepB at any one time, and 115 with HCV at any one time.

Hepatitis C viral infection is a significant public health problem and prisoners have a high prevalence of hepatitis C virus infection compared with the general population in England and Wales.

Prevalence of HIV amongst adult male prisoners is estimated at 0.3%. We know that nationally incidence of HIV in prisons increased during the 1990’s. However, it is believed that this observation was exaggerated by improved detection of these diseases and has since levelled off.

In the past ten years (2002-2011) there have been a total of 13 individuals who received their first UK HIV diagnosis while at HMP Wormwood Scrubs. No new diagnoses have been reported since 2006 (Health Protection Agency, 2012).

**Immunisations 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 common childhood disease in the UK and may not have been vaccinated in childhood.

Regular immunisations are offered to prisoners for Hepatitis B and Influenza in HMP Wormwood Scrubs.

The high prevalence of blood borne viruses in prisons has been acknowledged and it should be ensured that all prisoners have received a complete course of three Hepatitis B vaccinations. Drug users in particular should be covered by vaccination.
The graph below shows the percentage of new prisoners vaccinated against Hep B since July 2010. The average vaccination rate of new prisoners each month across this period is 21%.

Influenza

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

- Large numbers of individuals living in close proximity to each other.
- 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 prisoners with long term conditions.

Tuberculosis

Like most prisons, there is currently no reliable information on TB diagnosis in HMP Wormwood Scrubs. 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 per 100,000 prisoners per year, although this is likely to be an underestimate.

The prison does currently have a specialised X-Ray facility to screen for TB which is inactive due to lack of capacity. This is due to be employed in 2012 which should increase the levels of prisoner care and prevalence data.
Wider Determinants of Health

Smoking

In HMP Wormwood Scrubs, 50% of all new prisoners are recorded as current smokers by the prison services. This figure is however very variable due to the high turnover within HMP Wormwood Scrubs.

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. For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease.

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 underweight and less likely to be classified as overweight or obese (Bridgwood and Malbon, 1994)

However, with the increase in levels of obesity in the lower socioeconomic groups in the wider community in the last decade, it might be more sensible to hypothesise that, as shown with asthma and diabetes in similar socioeconomic groups, obesity is an emerging issue in prisons.

Physical Activity

Physical Activity programmes are available for prisoners every day of the week between 7.30am and 12 noon and again from 1.30pm until 4pm. Courses are offered between 4.30 and 6pm for those who are employed within the prison.

Examples of programmes offered include wing-based activities, football, volleyball, basketball, circuit training, over 50’s healthcare, remedial, and gym.

Education

A prison service study, which asked prisoners on reception to take a literacy test devised by the Basic Skills Agency, equivalent to the reading skills expected of 9 to 10-year-olds, showed that 60% of prisoners had problems with literacy, and 40% had severe literacy problems.

Nationally, the Social Exclusion Unit reported that 80% of prisoners have writing skills at or below the level expected of an 11-year-old child; the equivalent figure for reading is 50% (Social Exclusion Unit, 2002).15

Literacy is thought to be linked to criminality and literacy interventions in prisons are frequently seen to be the solution to the problems. This is an oft used common sense argument. However, the reality is more complicated and the relationship between literacy and crime needs to be looked at in a different and more complex light. Nevertheless, prisoners have poor literacy compared to the general population, and literacy is essential for an individual’s success.

HMP Wormwood Scrubs has a strong education department offering 88 full courses in subjects as wide as basic literacy and numeracy, multiple crafts, I.T., communication, personal development and business. These 88 courses are made up of a combined total of 2,388 modules, providing incremental learning on a

15 Cited in http://www.literacytrust.org.uk/assets/0000/0422/Literacy_changes_lives__prisons.pdf
wide variety of topics (something which healthcare could learn from or engage with in progressing a self-management of long-term condition agenda).

In total in 2011/12, 1,336 courses were completed and achieved by prisoners at HMP Wormwood Scrubs, with a further 144 awaiting results. This indicates a completion rate of 69% of the total 2,141 courses prisoners were enrolled on - a significant achievement given the fluctuation of the prison population. The courses where the most numbers of prisoners completed and qualified are listed in the table below:

### Table 4 - Top 10 educational courses in 2011/12 by number of prisoners qualified

<table>
<thead>
<tr>
<th>Course</th>
<th>Achieved</th>
<th>Achieved (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSCAWARD Award in Health &amp; Safety at Work (QCF)</td>
<td>173</td>
<td>81.99%</td>
</tr>
<tr>
<td>OCR Functional Skills qualification in English at Entry 3</td>
<td>99</td>
<td>88.39%</td>
</tr>
<tr>
<td>MULTI Word Processing Software</td>
<td>61</td>
<td>57.01%</td>
</tr>
<tr>
<td>OCR Functional Skills qualification in English at Entry 1</td>
<td>59</td>
<td>95.16%</td>
</tr>
<tr>
<td>ESB Certificate in ESOL Skills for Life (Speaking &amp; Listening)</td>
<td>51</td>
<td>62.96%</td>
</tr>
<tr>
<td>MULTI Spreadsheet Software</td>
<td>50</td>
<td>61.73%</td>
</tr>
<tr>
<td>OCR Functional Skills qualification in English at Entry 2</td>
<td>46</td>
<td>75.41%</td>
</tr>
<tr>
<td>MULTI Desktop Publishing Software - QCF Units</td>
<td>42</td>
<td>65.63%</td>
</tr>
<tr>
<td>ESB Certificate in Spoken Communication and Presentation</td>
<td>38</td>
<td>58.46%</td>
</tr>
<tr>
<td>MULTI Database Software - QCF Units</td>
<td>37</td>
<td>64.91%</td>
</tr>
</tbody>
</table>

Currently, there are 174 prisoners identified as continuing learners within HMP Wormwood Scrubs. The most popular course subjects and the numbers of prisoners enrolled are listed in the table below:

### Table 5 - Top 10 educational courses in by current number of ongoing learning prisoners

<table>
<thead>
<tr>
<th>Course</th>
<th>Learners</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESB Certificate in Spoken Communication and Presentation</td>
<td>16</td>
</tr>
<tr>
<td>BSCAWARD Award in Health and Safety at Work (QCF)</td>
<td>13</td>
</tr>
<tr>
<td>NCFE Introductory Award in Radio Production</td>
<td>10</td>
</tr>
<tr>
<td>MULTI Desktop Publishing Software - QCF Units</td>
<td>9</td>
</tr>
<tr>
<td>BCS Certificate in IT User Skills (ECDL Extra)</td>
<td>9</td>
</tr>
<tr>
<td>OCR Functional Skills qualification in English at Entry 3</td>
<td>6</td>
</tr>
<tr>
<td>MULTI Design Software</td>
<td>6</td>
</tr>
<tr>
<td>MULTI Word Processing Software</td>
<td>5</td>
</tr>
<tr>
<td>OCR Certificate in Adult Literacy</td>
<td>5</td>
</tr>
<tr>
<td>NCFE Award in Creative Craft</td>
<td>5</td>
</tr>
</tbody>
</table>

This data identifies with the fact that prisoners can be engaged in activities that are both useful to the prison and to the prisoners on their release. Furthermore, the scope of subjects offered allows prisoners to engage in a way that best suits their needs and own personal interests. The literacy and education department arguably offers an expression of liberty in a closed environment and healthcare should investigate this relationship in attempting to engage patients in healthy behaviours.
Dental Health

Decayed, missing or filled teeth (DMFT) 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.

Table 6 below shows that prisoners have on average 4.2 DMFT and approximately 58.0% to 64.7% of prisoners have at least one such tooth. This compares to a national average of 1.5 DMFT per adult and 55% of the population having at least one such tooth.

Table 6 - Comparison of the dental health of prisoners with the general population
(Community Dental Health, 2005)

<table>
<thead>
<tr>
<th></th>
<th>Prison Population</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners with 1+ DMFT</td>
<td>61.40%</td>
<td>55.00%</td>
</tr>
<tr>
<td>Mean DMFT per Prisoner</td>
<td>4.2</td>
<td>1.5</td>
</tr>
</tbody>
</table>

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.
Palliative / End of Life Care

There is little evidence regarding the prevalence or need for palliative or end of life care within the prison environment.

A recent evaluation by Lancaster University in 2009 - ‘Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire’ - concluded that compared to the general population the needs of prisoners for palliative or end of life care is small, however, does make some recommendations around policy, practice, training and research\textsuperscript{16}.

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. 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.

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.

\textsuperscript{16} Turner M, Payne S. Kidd H, Barbarachild Z. Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire
Minority Ethnic Groups

As we have already seen, HMP Wormwood Scrubs regularly houses a high proportion of prisoners from a minority ethnic background. Numbers of prisoners from minority ethnic groups in HMP Wormwood Scrubs are at a higher rate than seen nationally. At any one point it is expected that over half of the prison population is from a minority ethnic group.

Nationally, between 1999 and 2002, numbers of black prisoners increased by 51%. In 2003, as many as one in four prisoners were from a minority ethnic group compared to one in 11 in the general population.

Despite literature campaigning for the rights of minority ethnic groups, there is little research in this area in prisons. Two research teams have specifically addressed ethnicity of prisoners in relation to health issues (Coid et al, 2002; Borrill et al, 2003).

Work by Borrill et al (2003) illuminated the very different needs of prisoners from minority ethnic groups who have substance misuse problems. When assessing the substance misuse treatment needs of minority prisoner groups, Borrill et al (2003a) found that the drug treatment services appeared to direct treatment to heroin use (mainly White and Asian prisoners), to the possible detriment and discrimination of crack-cocaine users, who are black in the main.

Coid et al (2002) explored ethnic differences regarding criminality and psychiatric morbidity among male prisoners in England and Wales, and found evidence that black prisoners have a lower prevalence of psychiatric illness than white prisoners. These findings contrast with the evidence that high numbers of African-Caribbean prisoners are held in secure hospitals and prisons. It is suggested that this could be a result of complex factors, such as referral of prisoners with mental health problems, gate-keeping by mental health professionals and identification of prisoners with a mental health problem, which may influence prevalence rates.

Suggested further research for the healthcare unit regarding ethnicity and prisoners should include:

- Ethnicity and Diabetes (research in the general population shows clear links between minority ethnicity and Diabetes. With such a large minority ethnic population in HMP Wormwood Scrubs, it is expected that Diabetes prevalence may be disproportionately high.)
- Ethnicity and Literacy (with a large foreign national population lacking strong English and a minority ethnic community largely socioeconomically deprived before entering prison, research should be focused on techniques of improving levels of literacy and how this can benefit healthcare).
- Ethnicity and Religion and its impact on healthcare decisions.

Foreign National Prisoners

There are around 9,000 foreign national prisoners in England and Wales with distinct physical and mental health needs.

Nationally, concerns have been raised with regards to the problems of communication where English is not the prisoners first language, and their extreme vulnerability to isolation and depression (HM Inspectorate of

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Prisons for England and Wales, 2004. Almost 90% of the prisons holding foreign nationals are not accessing the translation service available.

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.

Concern about the high numbers of foreign nationals who have committed suicide is also rising; with as many as 35 foreign nationals in prison have taken their own lives between 2000 and 2004 (Prison Reform Trust 2004).

HMP Wormwood Scrubs has a particularly high number of foreign national prisoners.

Older Prisoners

While the number of older prisoners in HMP Wormwood Scrubs is currently low, it is predicted to rise alongside patterns nationally. The healthcare needs of older prisoners is disproportionately high compared to that of their younger counterparts, and a significant increase in older prisoners is likely to increase pressure on an already high level of healthcare need in HMP Wormwood Scrubs.

Prisoners aged 60 years and over represent approximately 2.5% of the total prison population (Home Office, 2002), but in the past decade, the rate has trebled and is the fastest growing group within the prison population (HMCIP, 2004). One in 10 older prisoners comes from a minority ethnic group; a ratio far higher than in the general population (Prison Reform Trust, 2005).

The work of Fazel et al (2001) added considerably to the research evidence of older prisoners’ physical health needs in England and Wales. Older prisoners have significant health needs, with 83% of older male prisoners reported a longstanding illness or disability, significantly higher figures than found in equivalent studies of younger inmates and community-based elderly men (65%).

Fazel et al also highlight that for male prisoners aged 60 years and over, the most commonly reported physical problems were musculoskeletal, cardiovascular or respiratory in nature. While HMP Wormwood Scrubs houses relatively few older prisoners, the impact of the prison environment on the impaired functional ability and dependency needs of many older inmates is a cause concern.

Furthermore, mental health services in prisons are, by and large, aimed at the younger, more vocal prison population, and older prisoners may be in danger of being ignored or fobbed off as a result (HMCIP, 2004).

Drug Users

A study of young men in prison with identified problems related to substance misuse, reported that their drug use behaviours were, like the general population, characterised by a ‘pick and mix’ approach and differed from the older prison population with an increased use of dance drugs, and greater stigma attached to the use of heroin and injecting, particularly among those from minority ethnic groups (Borrill et al., 2003).

One fifth of this sample claimed to have injected drugs at some time; at least half of these reported sharing equipment.

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21 www.parliament.uk/briefing-papers/SN04334.pdf
While drug use may have become socially 'normalised' among the young offender population, their drug use was not necessarily problematic or linked to their offending, and must be considered within the context of the wider problems facing these young people (Hammersley et al., 2003). The relationship between drug use and offending is therefore extremely complex.

In national studies, the use of more socially acceptable substances (alcohol, tobacco and cannabis) was useful in the prediction of offending compared with the use of other drugs. Hammersley and colleagues (2003) also found no evidence to support the progression to heroin/cocaine use and intravenous administration described among delinquents in the 1980s.

There is a lack of evidence regarding the impact of ethnicity on drug use behaviours of young offenders.

**Families of those Imprisoned**

Imprisonment also has an effect on partners and families. Research by The Social Exclusion unit found that:

- More than two in three of all prisoners are unemployed when they go to jail. Importantly for HMP Wormwood Scrubs, 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.
- Remand prisoners are more likely than sentenced prisoners to have a history of living in unstable or unsuitable accommodation. Research by the 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.
- In 2006, more children were affected by the imprisonment of a parent than by divorce in the family.
- Home Office research has found that 59% of men in prison have dependent children under 18.
- 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%.
- In recent years the number of prison visits has fallen despite an increasing prison population.

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26 www.nacro.org.uk
Provision of Health Services

The Offender Healthcare team provide patients with equitable care in accordance with nationally agreed standards for care delivery and planning. The service treats all prisoners as individuals, taking into account as far as possible their personal and cultural preferences.

Current service provision includes:

- Initial assessment and induction to the prison environment
- Detoxification & drugs management
- Primary care/ GP services
- Acute inpatient care for specified medical conditions
- Resettlement planning for reintegration to the community
- Safe management of socially controlled prisoners in segregation
- Day programmes for those with primary and secondary mental health issues offering individual assessment and support and group interventions intended to develop prisoners’ self-awareness & esteem, life planning skills and condition management.

Following the health screening processes made available to all prisoners upon reception to the prison, prisoners may self-refer or be referred to specialist wing clinics and the health centre.

Outpatient clinics are provided onsite in the health centre and referrals to dentistry, podiatry, optometry, sexual health services, and urology, are made via nursing staff.

Specialist medical referrals to acute trust consultants/ clinics are made via Primary Care and transport and escort are arranged by healthcare and coordinated with prison Security.

Substance Misuse and Mental health in-reach services are provided in partnership by Central and North West London NHS Foundation Trust.

See Appendix 2 for a full list of healthcare staff and the frequency of their services in HMP Wormwood Scrubs.
Routine healthcare is provided by a team of primary care nurses and GPs during business hours, seven days/week via wing based surgeries and treatment rooms.

Additionally there is an out of hours service provided.

An extended service is provided in the reception & first night units to cater for newly remanded prisoner healthcare needs.

The diagram below shows the route of a prisoner and the indicators recorded upon accessing primary care services at HMP Wormwood Scrubs.

Specialist Out-patient clinics are provided onsite in the health centre for dentistry, podiatry, optometry, sexual health, and urology. Referrals to these services are made via nursing staff from the wings, and prisoners are escorted to the health centre by prison guards.

**General Practitioner**

General primary care services are provided to prisoners on the wing that they are housed and within the prison health centre. General consultations are either by GPs or specifically trained nurses.
Wing Based Activity

Table 7 below shows the frequency of appointments offered attended and not attended in the last 12 months available.

Activity across all the wings A-D is relatively similar in terms of appointments offered, ranging from 1,337 at the most in A Wing to 1,184 at the least in D Wing. E Wing had the fewest appointments offered with 907 across this time period.

Attendance for wing based activity differs across the wings. DNA rates in C wing are particularly high. During the period shown average DNA rates for each of the wings were as follows:

- **A Wing**: 8.15%
- **B Wing**: 10.82%
- **C Wing**: 13.00%
- **D Wing**: 1.69%
- **E Wing**: 11.47%

It is understood that the majority of wing based GP consultations in prison concern minor illnesses, and health service provision is therefore expected to be similar to services provided in the community.

Amongst the most frequent issues raised at GP consultation are requests for prescription drugs, minor injuries, respiratory conditions, physical injuries, minor infectious diseases and skin disorders.

It has however been noted that a large proportion of GP visits have been for podiatry and musculoskeletal/mobility issues. These are key areas where primary care can provide simple and effective services which can help benefit the lives of prisoners both during and after their term.
Smoking Cessation

Smoking Cessation services are provided within HMP Wormwood Scrubs in partnership with Kick It, a specialist Stop Smoking treatment and advisory organisation based in Hammersmith & Fulham.

Healthcare assistants are trained to be Smoking Cessation Advisors and run groups or do individual one to one’s. In the sessions they offer education, support, promote peer support and leadership, provide Nicotine Replacement Therapy (e.g. patches and gum) or other medication (e.g. Champix) on prescription.

Weekly Carbon Monoxide checks are also completed to demonstrate health benefits to patients.

As part of the drive to increase self-management of conditions within the prison and the wider community, group members or individuals are encouraged to become trainers to continue the service informally within the prison, however, due to transitional nature of the population at HMP Wormwood Scrubs is difficult to record the benefits locally, but it is hoped that this training can provide benefit to other prisons as prisoners take this knowledge once transferred, and to the wider community on prisoner release.

Table 8 below shows the number of prisoners entering the prison each month who are recorded as smokers and those who have been referred to Stop Smoking services and the clinical outcome of their cases. This data is complicated by the length of time it takes to recorded Smoking ‘quits’ and the transitory nature of the prison population.

The data above shows approx. 1.2% of all smokers recorded quit. This is slightly lower than the rate seen in the local community of Hammersmith and Fulham (approx. 1.4%) which has high rates of smoking quitters when compared to London and England.

Interestingly most parts of deprived areas of H&F have high number of smoking quitters. However, more smoking quitters need to achieve in areas such as Sands End, North End and College Park and Old Oak.

Depression Alliance

As part of the development of Primary Care Mental Health service provision a 3 month pilot project was undertaken in partnership with Depression Alliance to seek to improve the health and wellbeing of men in Wormwood Scrubs with experience of depression. Sessions were a mix of educative and reflective techniques to promote health and wellbeing, to develop self-management techniques to identify early warning signs of depression and its impact.

Day programmes for those with primary and secondary mental health issues offering individual assessment and support and group interventions intended to develop prisoners’ self-awareness & esteem, life planning skills and condition management.
The table below show the number of prisoners who attended the weekly Depression Alliance group. The maximum group number is 8 places.

<table>
<thead>
<tr>
<th>Week Commencing</th>
<th>Number of Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/06/2012</td>
<td>5</td>
</tr>
<tr>
<td>20/06/2012</td>
<td>4</td>
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<td>01/08/2012</td>
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<tr>
<td>05/09/2012</td>
<td>4</td>
</tr>
<tr>
<td>12/09/2012</td>
<td>3</td>
</tr>
</tbody>
</table>

The report of the Depression Alliance pilot is currently being drafted and is expected by the end of 2012 commenting on the effectiveness and scope of the project to date.

**Book Break**

Book Break is a facilitated reading group which happens twice weekly in the prison. The goal is to provide a supportive reading and listening environment which helps to prevent depression, improve wellbeing, increase literacy levels and support effective social interaction and communication.

This replicates within the prison, the range of support services that are available within the community. The scheme has been running locally within Kensington & Chelsea since 2008 but there have been other initiatives across the country, which have taken the model into the forensic setting.

**Musculoskeletal and Mobility Issues**

Currently limited MSK and mobility help services are provided within the prison.

However, we know that MSK and mobility issues caused by low level injury are some of the most common issues highlighted to GPs within community based services for the comparative demographic to that of the prison population at HMP Wormwood Scrubs.

Analysis to date suggests that the raising of issues around MSK is parallel to that in the community for the demographic, given the data caveats, this would suggest that MSK need is high (approx. 8%) and likewise podiatry (severe podiatry 2.5%).

The most common diagnoses for MSK and mobility issues within HMP Wormwood Scrubs are the following, with the number of prisoners seen in 2011/12 in brackets - Knee Pain (20), MSK Pain (14), Ankle Injury (10), Chronic Sciatica (8) and Hand Injury (7).

The difficulty in providing MSK services is in a prison environment is exacerbated by many factors, including the high turnover of prisoners, the dichotomy between a sedentary lifestyle and physical exercise that occurs in prisons, and a lack of integration and buy-in of prisoners into systems which may benefit their lifestyles in the long term.
However, it is suggested that by providing modular assistance to prisoners in terms of physiotherapy, exercises and physical learning about their own musculoskeletal systems in HMP Wormwood Scrubs problems as far reaching as mobility to Diabetes to Mental Health may be neutralised.

This modular format will also give prisoners simple bits of healthcare advice in a way that can be replicated if they are moved to other prisons, or back in the community.
Specialist outpatient clinics are provided by HMP Wormwood Scrubs onsite in the health centre for the following conditions - dentistry, podiatry, optometry, sexual health, and urology.

These services are staffed by fully trained professionals in each specialty but are not available around the clock.

All referrals to these services are made via nursing staff from the wings. Waiting times vary dependant on the specialty (see Diagram 2).

DNA rates for specialist out-patient activity are high. There are multiple reasons why this is the case, but in a closed environment such as a prison many can be overcome with more integrated working. The main reasons why DNA are believed to be so high are as follows:

• Other pressures within the prison impacting on staff availability.
• Lack of an escort from the wing to the health care centre to attend an appointment.
• Apathy amongst the prisoners towards healthcare.
• Cultural / Religious attitudes towards healthcare needs.
• A lack of understanding of the services being offered.
• The lack of a coordinated reminder system for appointments from healthcare staff to prison guards / prisoners.
• Prisoners being transferred out of the prison prior to the appointment being completed.
• The lack of a reserve list system.

It is understood that a current Workstream is in place in HMP Wormwood Scrubs to deal with DNA rates effectively, which is believed to be having some success; however, it is apparent that it is still a major issue requiring significant work to reduce them completely.

The next few paragraphs will highlight the attendance rates for the specialties offered in the HMP Wormwood Scrubs and the demographic of those people attending.
**Dentistry**

Each dental session is provided by one dentist and a dental assistant with health promotion literature available. No hygienist is currently available. Dental sessions are available in the HMP Wormwood Scrubs healthcare unit in the morning and afternoon sessions of Monday, Tuesday and Thursdays, and the morning sessions of Friday - except for the first Tuesday of each month. There are no regular services available at the weekend.

Dental services have a high demand from prisoners. There is currently a 8-10 week wait for an appointment to the Dental specialty.

Table 10 below shows the frequency of appointments offered attended and not attended in the last 12 months available.

The number of dentistry appointments offered per month are between 149 and 251, with an average of 196 appointments offered per month. This is in effect offering an appointment to a minimum of a tenth of the prison population in any one month, indicating that dental issues are particularly acute within HMP Wormwood Scrubs.

DNA rates are high for the dental specialty at an average of 19% across the last 12 months available at the time of writing. This is however down from an average of 26% DNA between April 2010 and March 2011, so improvement is being made.

| Table 10 - Dentistry Out-Patient Activity, HMP Wormwood Scrubs Data (2012) |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
|                             | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Last 12 Months |
| Dentistry                   |         |         |         |         |         |         |         |         |         |         |         |         |                 |
| Appointments Offered        | 230     | 231     | 231     | 231     | 230     | 219     | 189     | 149     | 158     | 181     | 161     | 163     | 2357           |
| Attended                    | 170     | 169     | 193     | 166     | 175     | 183     | 148     | 193     | 165     | 149     | 154     | 154     | 1906           |
| DNA                         | 55      | 71      | 58      | 65      | 55      | 31      | 40      | 26      | 5       | 13      | 9       | 5      | 451            |
| % DNA                       | 24%     | 31%     | 23%     | 28%     | 26%     | 14%     | 21%     | 17%     | 3%      | 8%      | 15%     | 3%      | 19%             |

Chart 13 below highlights the age profile of those prisoners attending Dental outpatient services in HMP Wormwood Scrubs in the last 12 months. The age profile of prisoners attending Dentistry services is reflective of the general population of the prison, with the prisoners most likely to attend in the 25-39 age group.

There are higher numbers of older prisoners attending dental services and lower numbers of younger prisoners (aged 18-24) than the general population. This is indicative of a similar need for dental services in the wider community.
Excluding those for whom ethnicity was not specified, it seems that the ethnicity profile of prisoners attending is relatively reflective of those of White and Black / Black British origins in the wider prison population. However, those of Other origin are over represented and those of Asian / Asian British and Mixed origin are underrepresented.

However, data quality is extremely poor, with ethnicity not specified for 44% of the population who attended.

Podiatry

Podiatry services are provided by a qualified podiatrist, working alone with health promotion literature available. Severe cases will be referred onwards for care in an outside hospital. One session a week is provided in the healthcare unit on Wednesday mornings.

There is currently a 5 week wait for an appointment to the Podiatry specialty.

Table 11 below shows the frequency of appointments offered attended and not attended in the last 12 months available.

The number of podiatry appointments offered per month are between 16 and 70, with an average of 33 per month across the last 12 months data. This is indicative of a relative low capacity for this specialty.

DNA rates are high for the podiatry specialty at an average of 18% across the time period shown. This is however down from an average of 34% DNA between April 2010 and March 2011, so again some improvement is being made.

Chart 14 below depicts the ethnicity profile of patients attending outpatient dentistry services in the last 12 months.

Chart 14 - Ethnicity of prisoners attending Dentistry Out-Patients at HMP Wormwood Scrubs (2012)

Table 11 - Podiatry Out-Patient Activity, HMP Wormwood Scrubs Data (2012)

<table>
<thead>
<tr>
<th></th>
<th>Sep-11</th>
<th>Oct-11</th>
<th>Nov-11</th>
<th>Dec-11</th>
<th>Jan-12</th>
<th>Feb-12</th>
<th>Mar-12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Last 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments Offered</td>
<td>31</td>
<td>16</td>
<td>28</td>
<td>31</td>
<td>35</td>
<td>33</td>
<td>21</td>
<td>10</td>
<td>31</td>
<td>29</td>
<td>28</td>
<td>50</td>
<td>399</td>
</tr>
<tr>
<td>Attended</td>
<td>25</td>
<td>11</td>
<td>20</td>
<td>19</td>
<td>18</td>
<td>29</td>
<td>12</td>
<td>45</td>
<td>28</td>
<td>26</td>
<td>29</td>
<td>66</td>
<td>328</td>
</tr>
<tr>
<td>% DNA</td>
<td>19%</td>
<td>31%</td>
<td>29%</td>
<td>39%</td>
<td>40%</td>
<td>12%</td>
<td>43%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
<td>6%</td>
<td>18%</td>
</tr>
</tbody>
</table>
than the general population of the prison. While the bulk of the appointments were still for prisoners in the 25-39 age group, there is an over representation of prisoners from the 40-49, 50-59, 60-69 and 70+ age groups.

Need for podiatry services in the wider community is largely required in older age groups, so the pattern seen in the prison is indicative of need in the community.

Chart 15 below depicts the ethnicity profile of patients attending outpatient podiatry services in the last 12 months. Excluding those for whom ethnicity was not specified, it seems that the ethnicity profile of prisoners attending is relatively reflective of those of Black / Black British origins in the wider prison population. However, those of Other origin and Asian / Asian British are over represented and those of White and Mixed origin are underrepresented.

Reasons for over representation of the Other and Asian / Asian British ethnic groups may be related to Diabetes.

However, data quality is extremely poor, with ethnicity not specified for 46% of the population who attended.
Urology

Urology services are provided by qualified Urologist with health promotion literature available. Currently, only one session per month can be offered within the healthcare unit on the first Wednesday of every month. Due to this, any cases identified as potentially being seriously detrimental to prisoners health will be referred onwards for care in an outside hospital.

There is currently a 4 week wait for an appointment to the Urology specialty.

Table 12 below shows the frequency of appointments offered attended and not attended in the last 12 months available.

Urology is a specialty that will affect older men more frequently than younger men. Given the demographic of HMP Wormwood Scrubs it is unsurprising that the number of urology appointments offered per month is low, with an average around 9.

DNA rates are particularly high for the urology specialty at an average of 26% across the time period shown. This is however down from an average of 33% DNA between April 2010 and March 2011, so improvement is being made.

Urology may have specific issues surrounding privacy and unwillingness to disclose conditions to staff or other prisoners that may also be having an effect on DNA rates.

<table>
<thead>
<tr>
<th></th>
<th>Sep-11</th>
<th>Oct-11</th>
<th>Nov-11</th>
<th>Dec-11</th>
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<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Last 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments Offered</td>
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<td>6</td>
<td>7</td>
<td>4</td>
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<td>6</td>
<td>11</td>
<td>13</td>
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<td>113</td>
</tr>
<tr>
<td>Attended</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>29</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>84</td>
</tr>
<tr>
<td>% DNA</td>
<td>14%</td>
<td>40%</td>
<td>57%</td>
<td>0%</td>
<td>35%</td>
<td>29%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>15%</td>
<td>8%</td>
<td>29%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Chart 17 below highlights the age profile of those prisoners attending urology outpatient services in HMP Wormwood Scrubs in the last 12 months. The age profile of prisoners attending urology services is older than the general population of the prison. While the bulk of the appointments were still for prisoners in the 25-39 age group, there is an over representation of prisoners from the 40-49, 50-59, 60-69 and 70+ age groups, and an under representation on younger prisoners under 24.

Need for urology services in the wider community is largely required in older age groups, so the pattern seen in the prison is indicative of need in the community.

However, caution must be taken when interpreting these figures because of the small numbers involved. There is no guarantee that this pattern would be replicated in the following twelve months.
Chart 18 below depicts the ethnicity profile of patients attending outpatient urology services in the last 12 months.

Data quality is extremely poor, with ethnicity not specified for 44% of the population who attended. This, in addition to the low numbers originally identified means that no significant analysis can be produced.

**Ophthalmology**

Optical services are provided by a qualified optician and a healthcare assistant, with health promotion literature available. Two optician sessions a week are currently provided within the prison healthcare unit, on Tuesday and Friday mornings - except for the first Tuesday of each month. No services are regularly available at the weekend.

There is currently a 5 week wait for an appointment to the Optical specialty.

Table 13 below shows the frequency of appointments offered attended and not attended in the last 12 months available.

The number of optical appointments offered per month are between 56 and 91, indicating that need for optical services is relatively high. Only 1 appointment was offered in May 2012 due to staff shortage.
DNA rates are particularly high for the optical specialty at an average of 33% across the time period shown. This is however down from an average of 41% DNA between April 2010 and March 2011, so improvement is being made.

| Table 13 - Ophthalmology Out-Patient Activity, HMP Wormwood Scrubs Data (2012) |
|---------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Ophthalmology                              | Sep-11 | Oct-11 | Nov-11 | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Last 12 Months |
| Appointments Offered                       | 56     | 37     | 56     | 56     | 74     | 82     | 56     | 36     | 71     | 80     | 63     | 85     | 780             |
| Attended                                   | 35     | 41     | 39     | 39     | 49     | 49     | 49     | 49     | 45     | 50     | 49     | 60     | 527             |
| DNA                                        | 21     | 44     | 33     | 52     | 56     | 58     | 32     | 31     | 3%     | 8%     | 35%    | 20%    | 33%             |

Chart 19 below highlights the age profile of those prisoners attending optical outpatient services in HMP Wormwood Scrubs in the last 12 months. The age profile of prisoners attending optical services is older than the general population of the prison. While the bulk of the appointments were still for prisoners in the 25-39 age group, there is an over representation of prisoners from the 40-49, 50-59, 60-69 and 70+ age groups, and an under representation on younger prisoners under 24. There is a particularly acute over representation in the 50-59 age group.

Need for optical services in the wider community is largely required in older age groups, so the pattern seen in the prison is indicative of need in the community.

Chart 20 below depicts the ethnicity profile of patients attending outpatient optical services in the last 12 months.

Excluding those for whom ethnicity was not specified, it seems that the ethnicity profile of prisoners attending is relatively reflective of those of White and Asian / Asian British origins in the wider prison population. However, those of Other origin and Black / Black British origin are over represented and those of Mixed origin are underrepresented.

However, data quality is extremely poor, with ethnicity not specified for 47.75% of the population who attended.
Sexual Health

Sexual Health services are provided by a GUM consultant with health promotion literature available. Sexual Health testing kits are regularly available. One session per week is provided in the healthcare unit on Thursday afternoons.

There is currently a 6 week wait for an appointment to the Sexual Health specialty.

Table 14 below shows the frequency of appointments offered attended and not attended in the last 12 months available.

The number of sexual health appointments offered per month are between 30 and 71.

DNA rates are high for the dental specialty at an average of 27% across the time period shown. This is however down from an average of 33% DNA between April 2010 and March 2011, so improvement is being made.

Chart 21 below highlights the age profile of those prisoners attending sexual health outpatient services in HMP Wormwood Scrubs in the last 12 months. The age profile of prisoners attending sexual health services is younger than the general population of the prison. The bulk of the appointments were still for prisoners in the 25-39 age group, but the amount seen is an over representation of prisoners from this group. Expected levels of need are seen from prisoners in the 18-24, 40-49 and 50-59 age groups. There were no prisoners about 60 attending the sexual health specialty in this time period.

Need for sexual health services in the wider community is largely required in younger age groups, so the pattern seen in the prison is indicative of need in the community.
Chart 22 below depicts the ethnicity profile of patients attending outpatient sexual health services in the last 12 months.

Excluding those for whom ethnicity was not specified, it seems that the ethnicity profile of prisoners attending is relatively reflective of those of Asian / Asian British and Black / Black British origins in the wider prison population. However, those of Other origin and White origin are over represented and those of Mixed origin are underrepresented.

Data quality is better for this specialty, with ethnicity not specified for 28.46% of the population who attended. However, this is still poor recording.
This is a highly significant area of health activity in most prisons. It also puts considerable operational pressures on the prison because of the security procedures necessary to prepare and safely manage an escorted prisoner to hospital.

An escort is an episode where a prisoner is escorted by security staff to attend hospital. This includes the transfer of prisoners to NHS mental health facilities.

A bed watch is a hospital admission of at least one night in length, during which the prisoner requires constant observation for security purposes.

The clinical governance of this area is particularly important to maintain an appropriate balance between the demands of patient care and custody. Function 2 of the National Security Framework discusses in detail the security issues and the need to liaise closely with local NHS trusts.

The level of security necessary in all cases must be kept under review to take into account, the prisoner’s developing medical condition, the physical surroundings in which the prisoner is located and any emerging intelligence.

The table below shows the numbers of both escorts and bed watches that were required between January and December 2012.

<table>
<thead>
<tr>
<th></th>
<th>Jan-12</th>
<th>Feb-12</th>
<th>Mar-12</th>
<th>Apr-12</th>
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<td>4</td>
<td>4</td>
<td>5</td>
<td>11</td>
<td>7</td>
<td>6</td>
<td>63</td>
</tr>
</tbody>
</table>

Chart 23 - Number of Escorts / Bed Watches, HMP Wormwood Scrubs (2012)
There is a specific pathway in place within HMP Wormwood Scrubs to assist with the early identification and treatment of individuals with Learning Disabilities.

Diagram 4 below highlights the pathway that identifies new prisoners and their subsequent treatment stages while being in the prison. This pathway can be summarised in the following steps:

- Patient would come in through Reception process and be picked up in the First Night Centre on the Part 2 Screen.
- There is a LD screen which is triggered and from that they would be referred to a Nurse with LD specialism.
- They may be managed on normal location or in Healthcare and receive support by the LD nurse.
- They may receive daily visits, be fast tracked to Day care or education.
- Due to vulnerability issues they are often transferred to an LD hospital.
- If located here, there may be close liaison with the Community LD team to facilitate care within prison or back to community.

A new specialist LD nurse has recently been recruited to work solely within HMP Wormwood Scrubs, and data on prevalence and treatment type should follow once the role has been substantiated.
Central and North West London Mental Health Trust provide in-reach and H3 mental health services for HMP Wormwood Scrubs. The team consists of a full-time specialist registrar, a consultant psychiatrist, and a team of registered mental health nurses.

The Seacole Centre is also a part of the Mental Health specialist pathway, which provides a weekly programme of activities to maintain and improve health or wellbeing, based on individual need assessments. Referrals were taken from any member of staff, and clients were assessed and could attend a six-week programme of activities, tailored to meet their needs. Patients from the inpatient unit and those subject to assessment, care in custody and teamwork (ACCT) were also catered for. Activities included art, drama therapy, pottery, relaxation therapy and yoga. At the time of our visit, there were 45 clients. Clients were assessed regularly, and documentation was particularly commendable.

Diagram 4 below highlights the pathway that identifies new prisoners and their subsequent treatment stages after referral to the Mental Health pathway.

The table below shows the number of new referrals to Mental Health services by month for the period June 2011 to May 2012. On average 64 prisoners per month are referred to the service. (See Table 19). The referral outcomes are also shown, highlighting that there has been a significant change over the last 12 months from the majority not being followed-up to most being followed-up. This is believed to be down to...
increased staffing, better detection of Mental Health issues on the wings, and better diagnosis in the Mental Health unit.

There are three types of follow-up to referrals from the mental health pathway: no action, referral for treatment on H3 (where they may also be referred for outside specialist care) or to the CPA pathway.

H3

On average 13 prisoners a month are referred to H3, and the unit runs near capacity all year round. See Table 20.

Of the prisoners that are referred to H3, all patients screened at reception who have been identified with an urgent Mental Health issue are referred to the Mental Health pathway and are expected to be screened within 24 hours.

All service users who are deemed to have a serious enough problem to be transferred out to an in-patient facility are expected to be transferred out within 14 days.

Those prisoners with issues identified that are not of immediate danger to their life are referred and are expected to have a routine assessment within 5 working days.

CPA

The caseload on of new prisoners referred to CPA across the 12 months of June 2011 to May 2012 averages at 25 prisoners per month. The total caseload per month averages at 62 prisoners at any one time.

Of the prisoners that are referred to the CPA pathway, it is expected that prisoners are required to have a nominated care plan within one month of being known to mental health services.

The table below shows how HMP Wormwood Scrubs have been managing in hitting these targets within the 12 months of June 2011 to May 2012.

### Table 15 - Number of referrals to specialist Mental Health services, HMP Wormwood Scrubs (2012)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>No - Follow-Up</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>40</td>
<td>34</td>
<td>20</td>
<td>16</td>
<td>15</td>
<td>21</td>
<td>55</td>
<td>27</td>
<td>55</td>
<td>355</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>65</td>
<td>767</td>
</tr>
</tbody>
</table>

### Table 16 - Number of referrals to specialist H3 services, HMP Wormwood Scrubs (2012)

<table>
<thead>
<tr>
<th>H3</th>
<th>Average No. of Prisoners</th>
<th>Admissions for Month</th>
<th>Previously Seen in Last 4 Weeks</th>
<th>Discharges for Month</th>
<th>ACCT (Average per Day)</th>
<th>1:1 Constant (Average per Day)</th>
<th>Est. Cost 1:1 for Month</th>
<th>Average Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-11</td>
<td>12</td>
<td>16</td>
<td>15</td>
<td>15</td>
<td>16</td>
<td>15</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Jul-11</td>
<td>14</td>
<td>18</td>
<td>18</td>
<td>16</td>
<td>13</td>
<td>15</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Aug-11</td>
<td>12</td>
<td>25</td>
<td>16</td>
<td>20</td>
<td>20</td>
<td>19</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Sep-11</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Oct-11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nov-11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dec-11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jan-12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feb-12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mar-12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr-12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>May-12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Of the prisoners that are referred to H3, they are expected to have a nominated care plan within one month of being known to mental health services.
### Table 17 - Referral Outcomes for Mental Health services, HMP Wormwood Scrubs (2012)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>All Service Users requiring an urgent assessment are seen within 24 hours of receipt of the referrals</td>
<td>75%</td>
<td>89%</td>
<td>88%</td>
<td>82%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>All Service Users requiring a routine assessment are seen within 5 working days of receipt of the referrals</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>All Service Users accepted for CPA are required to have a nominated care coordinator and care plan within 1 month of being known to CMHT</td>
<td>98%</td>
<td>96%</td>
<td>100%</td>
<td>91%</td>
<td>81%</td>
<td>87%</td>
<td>85%</td>
<td>100%</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>All service users who have been accepted for transfer to an in-patient facility are transferred within 14 days</td>
<td>0%</td>
<td>100%</td>
<td>50%</td>
<td>40%</td>
<td>60%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>63%</td>
<td>51%</td>
</tr>
</tbody>
</table>
The Conibeere Unit is the prison substance misuse Stabilisation Unit. It receives prisoners that test positive in reception and also those that test positive from the general prison population. Those who are admitted to the Conibeere Unit are those with an identified drug and alcohol problem that requires stabilisation. The diagram below shows the pathway for Substance Misuse.

Initially a prisoner will be screened by a healthcare nurse on reception to the prison. If a prisoner discloses drug use at this point, an immediate drug screening will be carried out. If the test is positive and requires clinical interventions, the prisoner will be admitted to the Conibeere Unit. Clinical need for admission to Conibeere Unit will be decided jointly by the reception nurse and the doctor.

On average the Conibeere Unit saw 128 prisoners a month (average between June 2011 and May 2012). Approximately 56% of all clients coming into the Conibeere receive a methadone prescription. The remaining have received alcohol prescribing interventions and other opioid substitute medication.

The table below shows the indicators collected for the latest 12 months in the Conibeere Unit.
There are discrepancies between the Conibeere data and the data submitted to DIRweb. This is due to treatment modalities not being captured using activity forms and the lack of a systematic approach to 28-day and 13-week reviews where this information can be picked up and reported. These are highlighted on the relevant pages.

Primary, Secondary and Tertiary Drug Use

In 2009 50% of prisoners had heroin as a primary drug type. This has fallen to 45% in 2011. Heroin as a secondary and tertiary drug type has stayed relatively constant and around 10% and 1% respectively. Since the improvements in identifying crack use in reception in 2010, its use has stayed constant: 1% identified as primary crack users, 24% as secondary crack users and 6% as tertiary crack users.

The identifying of cocaine users dropped significantly between 2009 and 2010. One possible explanation is that crack users were being identified as cocaine users. In 2011, 1% of prisoners had cocaine as a primary drug type, 7% had it as a secondary drug type and 4% had it as a tertiary drug type.

Primary & Secondary Drug Use 2011

The tables below show a breakdown of primary and secondary drug use as picked up in the Conibeere Unit. The Yellow boxes show the most common combinations of drugs: Alcohol only (28.2%, 2011); Heroin with Crack (22%, 2011); and Heroin with Methadone (8%, 2011).

Over the past three years Heroin was the most popular primary drug type, with 44.5% of prisoners using it in 2011. In the same year 35.7% of prisoners had alcohol as a primary drug type.

Offence Types of Conibeere Clients

Table 18 - Admissions to the Conibeere Unit by Type, HMP Wormwood Scrubs (2012)

Table 19 - Primary & Secondary Drug Use in the Conibeere Unit, HMP Wormwood Scrubs (2012)
In terms of offences of those prisoners passing through Conibeere, theft and handling offences have the highest occurrence.

44% of heroin and crack users are in prison for a theft and handling offence. 45% of heroin and methadone users are in prison for theft and handling. It is the same amount for heroin and cocaine users. 26% of those prisoners that use alcohol only are in prison for ‘other offences’, 19% are in for theft and handling, 17% are in for violence against the person.

First Night Prescribing

The First Night Prescribing Data has been collected in a slightly different manner each year from 2009-2011. It is shown in detail in the Substance Misuse JSNA.

2011 data indicates that 30% were given first night prescribing for alcohol and 69.6% were given first night prescribing for opioids. However, first-night prescribing data should be considered in light of transfers from other prisons. Majority of these prisoners do not require a first-night prescribing intervention as the transferring prison administer medication on the day of transfer.

<table>
<thead>
<tr>
<th>Conibeere Unit</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Prescription</td>
<td>3.40%</td>
</tr>
<tr>
<td>Methadone Only</td>
<td>52.80%</td>
</tr>
<tr>
<td>Subutex</td>
<td>1.10%</td>
</tr>
<tr>
<td>Alcohol Detox Only</td>
<td>31.20%</td>
</tr>
<tr>
<td>Both Methadone &amp; Alcohol Detox</td>
<td>11.40%</td>
</tr>
<tr>
<td>Alcohol Detox &amp; Subutex Detox</td>
<td>0.10%</td>
</tr>
</tbody>
</table>

Table 20 - First Night Prescribing in the Conibeere Unit

HMP Wormwood Scrubs (2012)

There are data gaps around multiple prescribing. It is not possible to ascertain if a prisoner is prescribed for more than one substance (e.g. alcohol and opiates).

Maintenance / Detoxification

In 2011 nearly half (49.5%) of prisoners were offered methadone maintenance only. Just under a third (30.8%) of prisoners were receiving and alcohol detoxification only. 11.3% of prisoners were offered methadone maintenance and alcohol detoxification.
A review of the literature and available best practice guidelines is included here to support future service reviews.

**Respiratory Conditions**

**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.

NICE produce specific guidance on pharmacotherapy for the management of chronic asthma TA138[^27] and TA139[^28].

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

**COPD**


The Department of Health has recently published an Outcomes strategy for COPD[^30]. 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.

**Long Term Conditions**

**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[^31].

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[^32][^33][^34].

**Epilepsy**

[^30]: Department Health 2011 An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma, DH London.
[^33]: National Institute of Health and Clinical Excellence. CG87 Type 2 diabetes - newer agents (a partial update of CG66): short guideline 18 June 2009
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\(^{35}\).

NICE Guideline on Epilepsy provides a good practice base from which to deliver equivalence of service for all NHS users, including prisoners\(^ {36}\).

**CVD**

National Service Frameworks on CHD and long-term conditions and NICE guidelines on chronic heart failure, hypertension, types 1 and 2 diabetes provide a good practice base from which to deliver equivalence of service for all NHS users, including prisoners\(^ {37}\). 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\(^ {38}\).

**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\(^ {39}\).

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.

NICE guidance CG 58\(^ {40}\) 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.

**On-going Disability and Learning Difficulties**

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\(^ {41}\).

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.

In addition, the DH has produced a handbook, for professionals in criminal justice system, which has practical introduction to learning disabilities as well as signposting to resources and organisations that can provide specialist support and advice.

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\(^{37}\) Department of Health (2000). National service framework for coronary heart disease - modern standards and service models


\(^{39}\) [http://guidance.nice.org.uk/CG27](http://guidance.nice.org.uk/CG27)

\(^{40}\) [http://guidance.nice.org.uk/CG58](http://guidance.nice.org.uk/CG58)

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.\(^{42}\)

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.\(^{43}\)

Screening for HCV has been reported to be an effective intervention in managing the disease. In addition, the current UK guidance on immunisations recommends vaccinations against Hepatitis B for all new prisoners entering prisons in the UK\(^{44}\)\(^{45}\).

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\(^{46}\).

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\(^{47}\)\(^{48}\).

According to WHO\(^{49}\), measures to prevent the transmission of infectious diseases among drug users include:

- 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.

Tuberculosis

For tuberculosis, in the absence of robust research on effective interventions, NICE guideline\(^{50}\) on tuberculosis provides recommendations on tuberculosis management in prison setting. The Chief Medical Officer action plan ‘Stopping tuberculosis’ in England identifies prisoners as an important part of the TB control strategy.\(^{51}\) It is important to raise awareness of signs and symptoms in prisoners, prison staff and...


\(^{44}\) Health protection agency. Infection Inside The Prison Infectious Disease Quarterly March 2011 Volume 7, Issue 1


\(^{47}\) 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


\(^{49}\) World Health organisation. Health in prisons A WHO guide to the essentials in prison health, 2007

\(^{50}\) 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)

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.\(^{52}\)

**Immunisations and vaccinations**

UK guidelines on immunisation against infectious diseases (The Green Book) should be the primary source of information on all issues in relation to vaccinations. The Health Protection Agency has also produced guidelines on vaccination requirements of prisoners. Advice on vaccination for an HIV-infected individual is available from the British HIV Association.\(^{53}\)

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\(^{52}\) Department of Health. Recommended standards for sexual health services 16 March 2005

\(^{53}\) [http://www.bhiva.org/Home.aspx](http://www.bhiva.org/Home.aspx)
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.

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. The prison substance misuse partnership delivers an annual needs assessment and treatment plan to ensure drug and alcohol needs are appropriately commissioned to meet need and the local demographic.

In addition, the cross-Government document ‘Safe Sensible Social’ updating the national alcohol strategy contains specific recommendations for offender populations.

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. 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. 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 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.

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54 NOMS (2005) Strategy for the management and treatment of problematic drug users within the correctional services. NOMS; London
58 http://guidance.nice.org.uk/CG51
59 http://guidance.nice.org.uk/CG52
The Department of Health has also provided guidance on the pharmacological management of substance misuse among young people in secure environments. 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.

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). 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.

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.

A substantial prison health needs assessment—alcohol has recently been undertaken in Scotland. 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.

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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 review64 places a great emphasis on the use of psychosocial interventions, including brief and extended treatments, for alcohol misuse, although the dearth of evidence base into the effectiveness of these interventions in a prison setting is acknowledged by the NTA review.

There are a range of NICE guidance and quality documents to support the commissioning of alcohol services:

- 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

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Wider Determinants of Health

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. 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.

NICE guidance:

- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007).
- 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).

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.

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:

- NICE public health intervention guidance 2 (2006)

Dental Health

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.

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65 Department Health 2011 Local Stop Smoking Services Service delivery and monitoring guidance 2011/12 London
67 www.nice.org.uk/CG043
68 www.nice.org.uk/PHI002
• 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.
• 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.
• 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.

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\(^70\) \(^71\).

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.

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.

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\(^70\) [http://pso.hmprisonservice.gov.uk/PSO_3200_health_promotion.doc](http://pso.hmprisonservice.gov.uk/PSO_3200_health_promotion.doc)
\(^71\) Dept. health 2002 Health Promoting Prisons: a shared approach. DH London
### Palliative and End Life Care

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\(^{72}\).

The HM Inspectorate of Prison's report, 'No problems - Old and Quiet' (2005)\(^{73}\), makes reference to the state of palliative care in prisons in the UK. 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.

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\(^{72}\) Turner M, Payne S, Kidd H, Barbarachild Z. Dying behind bars: an evaluation of end of life care in prisons in Cumbria and Lancashire

A 2 hour focus group with 5 prisoners was conducted to identify the main issues with healthcare in the prison. Below is a summary of the main issues arising from the discussion:

**Systems**

Lack of co-ordination, sharing information and communication between different sections of the prison to ensure that accessing healthcare was not hindered, for example education classes at the same time as an appointment at healthcare or lock up times not allowing for healthcare appointments. The regime change had also complicated issues with meal times and taking medication.

Lining up to get medications was stressful and unruly and not confidential as the prisoners often had to talk to the nurse about things they didn’t want other prisoners hearing.

**Appointments**

Not knowing the times for appointments or the waiting times for seeing a nurse/doctor. The group were frustrated at the waiting time for things like the dentist or optician and for missing specialist outpatient appointments because of changing appointment times.

It was suggested that appointment slips might be useful or using the PA system to inform prisoners of appointments. It was felt that a system for filling appointment times for prisoners who had left the establishment would be useful.

**Staffing**

Varied healthcare staffing levels on different wings, which can impact on the quality of care received, for example not enough time with just one nurse dispensing medication and giving advice. This was seen as a big risk to safety.

**Access**

Access for prisoners with a disability was identified as being hard as lifts were not always working and it was difficult to get around to access different services.

**Prisoner Consultation**

The group liked the idea of Healthcare reps and felt there should be several on each wing. The idea of having regular focus groups was seen as a good idea so that prisoners could talk about concerns with healthcare.

The group felt that feedback questionnaires could be useful.

**Services**

Some ideas for groups that would be useful to add to the Seacole Centre programme included anger management; parenting skills; life skills, anxiety management.

All the prisoners agreed that counselling would be useful to deal with anxiety and depression. It was felt that more Listeners and increased access to Listeners was important.

Book break was seen as good amongst the prisoners.
With the introduction of the Health and Social Care Act 212 all commissioning for those in secure accommodation has transferred to the NHS Commissioning Board from 1st April 2013. From this date the organisation will be known as NHS England. The Health in the Justice System team in London will have responsibility for healthcare delivery in all prisons and youth offending institutions (public and contracted), criminal justice liaison and diversion schemes in courts; police custody suites; immigration removal centres, sexual assault and referral centres and assist with the commissioning for secure training centres and children’s homes for young people.

This wide remit, delivered by a London team will offer opportunities for consistency of commissioning and procurement approaches; for consistency of building single service specifications and single performance dashboards in the model of “do once and share”.

The intention of the team is to continue to meet resource efficiencies whilst maintaining good quality care in the challenges environments in which we practice and deliver services to our patients.

NHS England, Health in the Justice System team will work collaboratively with our colleagues in the National Offender Management Service, UK Border Agency, Probation, the Police, our healthcare providers across NHS Trusts, Foundation Trusts, the voluntary and private sectors.

We will do this with the clear intention to drive up quality within the secure accommodation estates that will address the health inequalities in our patient population and assist our professional colleagues in using our expertise to help reduce reoffending.

NHS England’s objectives are:

1. **CQUINs**- the Provider will work with the Commissioner to deliver a quality improvement and innovation programme. The NHS CB guidance on this will be implemented.

2. **Performance dashboard**- the Provider will work with the Commissioner to implement a London-wide dashboard to support improvements of Public Health and NHS Outcomes.

3. **Equivalent access and delivery of Health services for offenders is a key principle of the service. The Provider will work with the Commissioner to deliver an assurance plan to include increase in screening, immunisations and access to treatment.**

4. **The NHSCB will be responsible for commissioning Secondary Care for patients from April 2013. Providers will monitor and report such activity to Commissioners to support future strategic planning.**

5. **Providers will work with Commissioners to improve continuity of care of patients on discharge from custody.**
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