Public Health England

Offender Health:

The Health & Well-being of people in contact with the Criminal Justice System.

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Ministry of JUSTICE
National Offender Management Service

Probation & Prisons Map

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Prison Population: Friday February 22, 2013

- The prison population **grew rapidly** between **1993 to 2008** – an average of **4% a year**.
- The rise in the prison population **slowed considerably** from the **summer of 2008** with an average annual increase of **1%**, until the public disorder seen in UK cities from 6th to 9th August 2011, which had an immediate impact on the prison population.

	Total	Prisons	NOMS Operated IRCs
Population	**84,424**	**83,637**	**787**
Male population	*80,465*	*79,678*	*787*
Female population	*3,959*	*3,959*	*0*

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Prison Population profile:

- The relative size of the **female** prison population has remained stable, at just **under 5%** of the total.
- Approximately **2%** of the current prison population are aged **less than 18 years**; **9%** are aged **18-21**, while **78% are aged 22- 49 years**.
- Between 2010 and 2011, the number of prisoners **aged 50 and over increased by almost 10%,** more than twice the increase in the total population. Currently this age group form **10% of the prison population**.
- **Around three-quarters** of all prisoners describe themselves of **White** ethnicity and **13% are Black or Black British**.
- In the last 10 years, the number of **foreign nationals** in prison has **doubled** and now represents **over 14%** of the total prison population in England and Wales.

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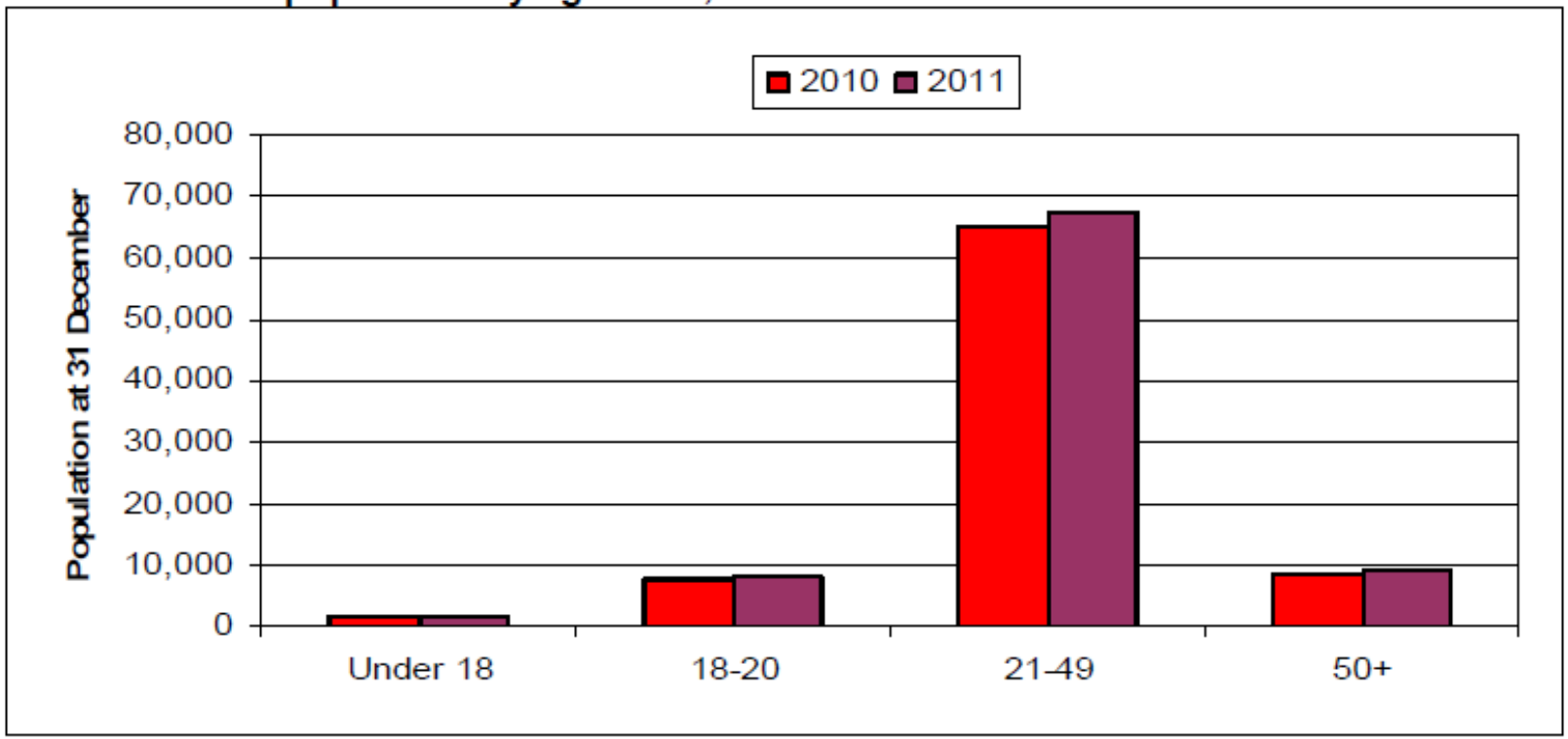
Prison Population by Age Band

Table 1: Prison population by age band, 2010 and 2011



Source: National Offender Management Service

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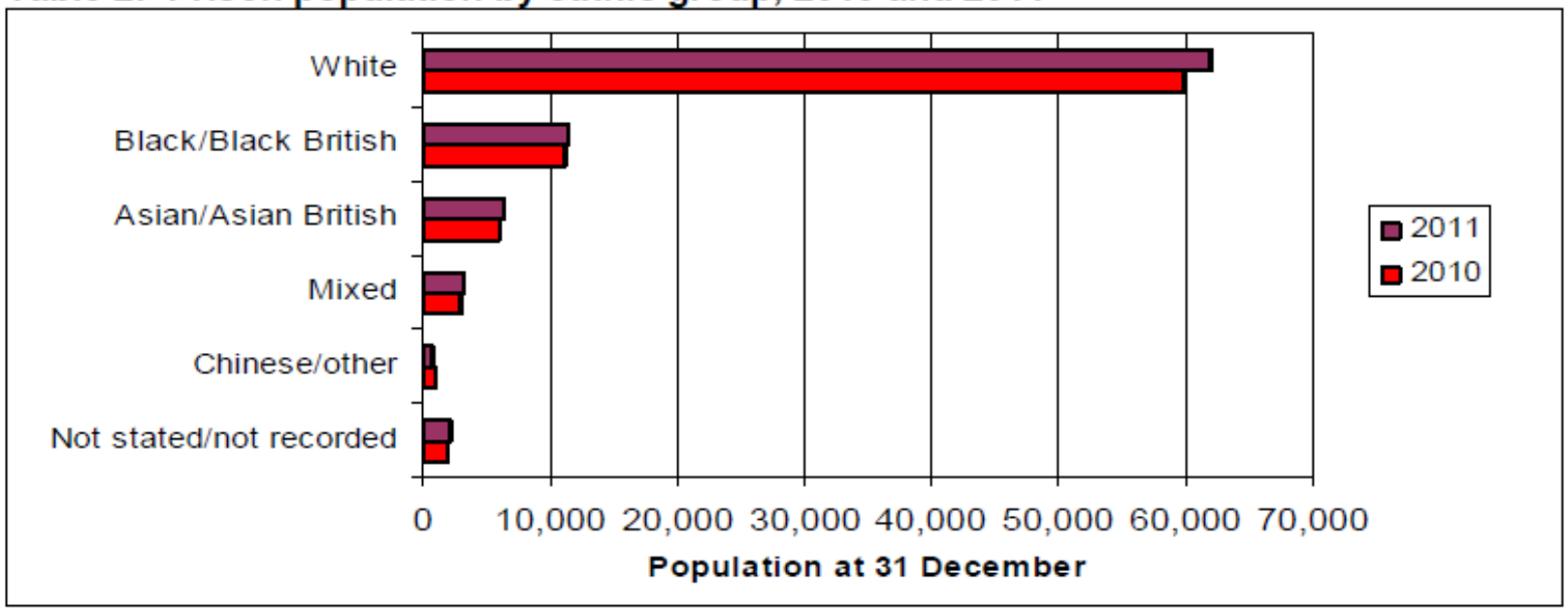
Prison Population by Ethnic Group

Table 2: Prison population by ethnic group, 2010 and 2011



Source: National Offender Management Service

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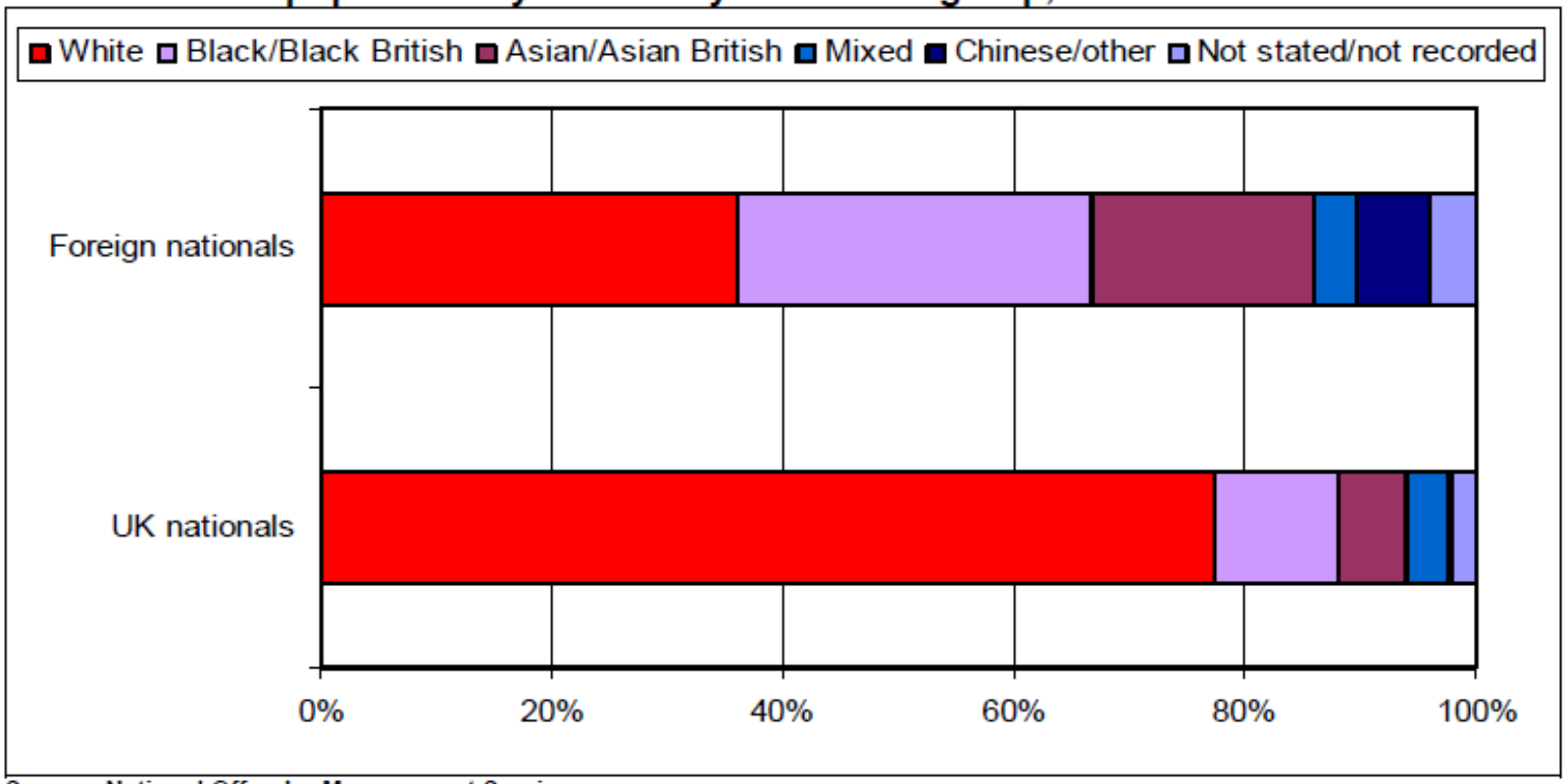
Prison population by nationality & ethnicity

Table 3: Prison population by nationality and ethnic group, 2011



Source: National Offender Management Service

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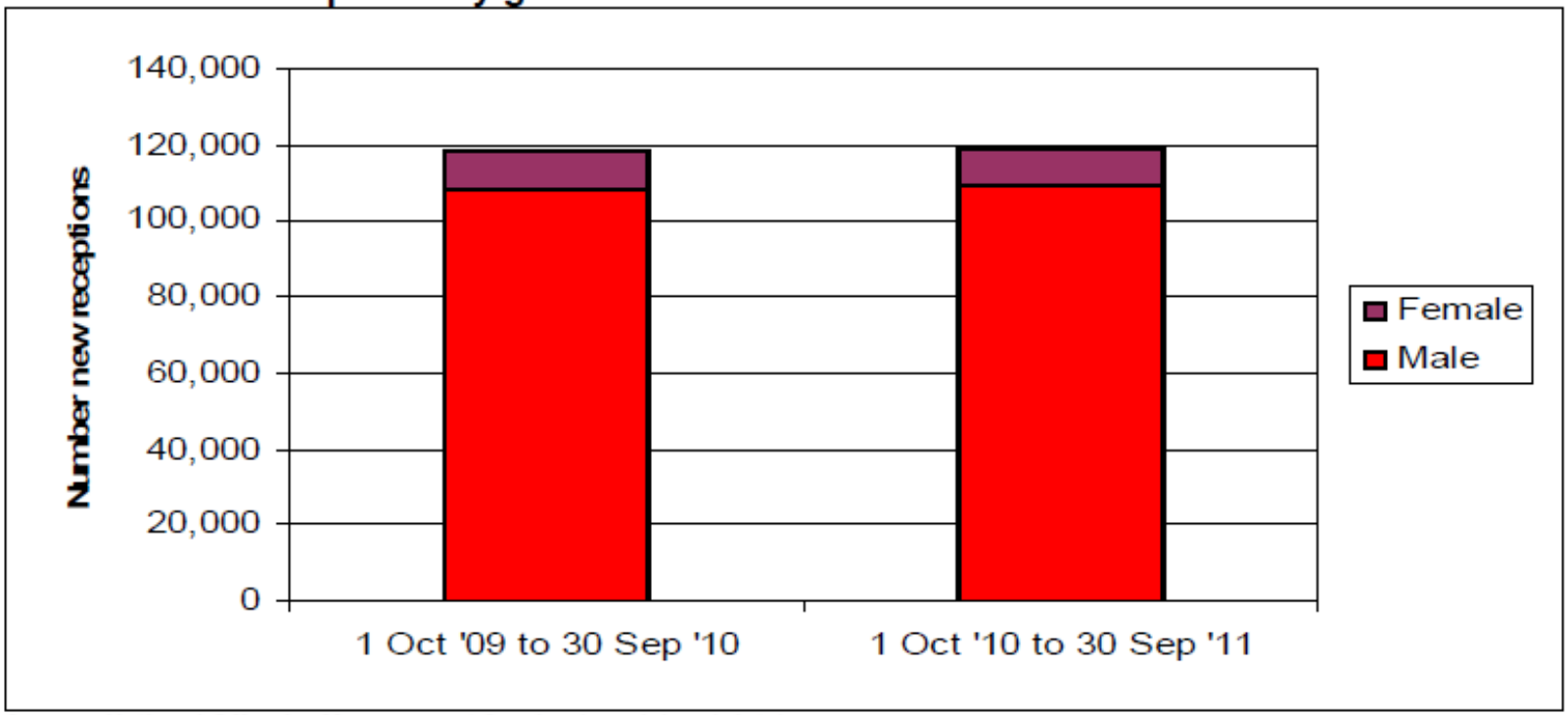
Prison Population Turnover

Table 4: First receptions by gender



Source: National Offender Management Service (provisional data)

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Health Needs of People in Prisons

- People in prescribed places of detention often experience **a higher burden of disease** (including infectious diseases, chronic illnesses and mental health problems), **poorer access to treatment and prevention programmes**, and **problems with substance misuse** (including drugs, alcohol and cigarette smoking) than their peers in the community. (Singleton, Meltzer, Gatward, Coid & Deasy, 1998)*.
- **Rates of homelessness, unemployment and a lack of basic level education** are high amongst offenders (Prison Reform Trust, 2006); as are rates of drug and alcohol dependency and mental illness

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Health Needs: Infectious Diseases

a. Burden of infection with **blood-borne viruses (BBVs)** and **sexually transmitted infections (STIs)** among prisoners is higher than in the general population:

- i. 8% of males and 12% of females are Hepatitis B positive, and 9% of males and 11% of females are Hepatitis C positive
- ii. 15% have had or have an STI;

b. The burden of disease with **tuberculosis (TB)** has increased year-on-year since reporting began in 2007 when there were 46 reports to 91 in 2012;

c. People **detained in IRCs** are more likely to have infections with **BBVs, HIV and TB** than their peers in the community.

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Health Needs cont'd

People in prisons have high levels of smoking, alcohol & substance use:

a. At least 80 per cent of prisoners smoke;

b. More than one third of women and almost two-thirds of men entering prison have an alcohol problem;

c. Two-thirds (69 %) of prisoners have used at least one drug during the year

d. About one third of all people treated for substance misuse in England are treated in prisons (60,000 prison clinical drug treatment episodes p.a./197,110 community treatment contacts 2011-12);

e. Significant premature mortality:

- 40% of natural deaths in custody are due to coronary artery disease, including those under 40;
- 25% of such deaths related to cancer.

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Children & Young People

- Children and young people in contact with the **Youth Justice System (YJS)** have greater levels of unmet health and well-being needs than their peers.
- **Opportunities for early interventions**, including childhood immunisations, are **frequently missed** due complex and fractured social and family circumstances that may be linked to **parental poverty, substance misuse and mental health problems.**
- The overwhelming majority of children and young people in contact with the YJS remain in the community throughout that contact, but a small number are remanded or sentenced to custody.
- **The health and well-being needs of children and young people in custody tend to be particularly severe.**

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Prison- a health opportunity?

- Under UK health policy, and international human rights policies, **prisoners and other people legally detained by the Criminal Justice System, are entitled to the same quality and range of healthcare services as those received by the general public** (HMPS/NHS executive, 1999; Council of Europe, 1998; United Nations, 1990).
- Therefore, **detention settings can represent an opportunity** to positively engage with people often classified as ‘hard to reach’ and identify and manage health problems.
- Furthermore, because most people in detention settings spend the greater part of their life in the wider community, **health gains made inside can have positive ‘ripple’ effects on their families and wider social contacts.**

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Mission Statement on Offender Health

- Public Health England (PHE) will work **in partnership** with **health and social care commissioners and service providers** to **identify and meet** the **health needs of people in prisons and other detention settings** (including police custody cells, immigration removal centres (IRCs) and the Young People's Secure Estate).
- PHE will aim to **reduce health inequalities**, **support people in living healthier lives**, and **ensure the continuity of care in the community**.

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Scope of work for PHE

- The scope of 'places of detention' includes:
  - **Prisons (public and 'contracted out' estate);**
  - **Immigration Removal Centres (IRCs);**
  - **Young People's Secure estate (including Secure Training Centres & Secure Children's Homes);**
  - **Police Custody Suites,**
  - **Courts.**
- Public health in prescribed settings covers all three dimensions of public health:
  - **health protection,**
  - **health improvement,**
  - **healthcare public health.**

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Policy Context

- Detention settings are a requirement of a functioning criminal justice system;
- The health and well-being of people in prescribed detention settings is a particular **responsibility of the state**;
- There is great variety in both the **nature of detained populations** and the **detention settings**, which adds a level of complexity.
- Some detention settings are the responsibility of the **Ministry of Justice, others of the Home Office.**
- Some detention settings are **publicly owned** whereas others are **'contracted out' to the private sector.**

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Challenges to commissioners

- **Commissioning of health services varies depending on the nature of the setting and its ownership.**
- **Providers** vary in terms of being public or private sector and in the nature and quality of care provided.
- **The nature of detained populations** in England means that certain infectious diseases, chronic illnesses, mental health problems and substance dependence are over-represented whilst the **nature of the detention setting** itself can create **obstacles** to the identification of health needs and / or the delivery of appropriate health services.
- There are particular challenges around **continuity of care** as detainees are **moved around the detention estate**, but **especially on transfer back to the community** where they often **fail to engage or be engaged by the NHS** and **social services** due to complex social and organisational reasons.

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New commissioning context

- Section 15 of the **Health and Social Care Act 2012** gives the Secretary of State the power to require the NHSCB to commission certain services instead of CCGs. These include **'services or facilities for persons who are detained in a prison or other accommodation of a prescribed description.'** Regulations allow the NHSCB to assume these powers from **April 2013.**
- The NHSCB will be responsible for **ensuring that services are commissioned to consistently high standards of quality across the country, promote the NHS Constitution and deliver the requirements of the Secretary of State's Mandate and the section 7a agreement with the NHSCB.**

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Benefits of new system

- The rationalisation of a large number of local commissioners to **one single national commissioner** provides the opportunity to implement nationally **consistent evidence-based commissioning specifications** and **quality standards** appropriate to the patient population and integrated in community-based services.
- The is an opportunity to improve the continuity of care as detainees move around the detention estate and / or back into communities.
- There are significant opportunities to improve the health and well-being of people in detention and in turn, **the wider community,** especially given the increased number of detention settings included within the remit of the NHSCB (e.g. IRCs).

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National Partners (Health)

- There are several key players **within health** at national level working to deliver public health services to people in contact with the criminal justice system:
  - a. **Department of Health:** Public Health Directorate (setting policy);
  - b. **NHS CB** (setting commissioning specifications for health services delivered in prescribed places of detention);
  - c. **PHE** (providing evidence, intelligence, data and guidance to advise policy-makers and offender health, local authority and criminal justice based commissioners).

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National Partners (CJS):

Key partners at national level from the Criminal Justice sector include:

a. **National Offender Management Service (NOMS)**
b. **UK Border Agency (UKBA)**
c. **Home Office**
d. **Ministry of Justice**
e. **Police**
f. **Youth Justice Board**

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Local Partnerships

- At local level, **PHE Centres and NHSCB ATs will also work together** to ensure that services delivered in prescribed detention settings are of **high quality, meet identified needs, are evidence-based and meet national policy objectives.**
- This work will include **effective collaboration and co-production** with Directors of Public Health, local authorities, Police & Crime Commissioners, Probation Services, CCGs and other statutory and non-statutory partners.
- Some of this partnership work may be affected through Local Prison Partnership Boards and/or Health and Criminal Justice Boards.

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Role of PHE in Offender Health

- PHE will **gather and provide evidence and intelligence** to inform and support the work of local and national commissioners and service providers;
- PHE will **provide expertise at local and national level** on a broad range of health protection, health promotion and disease prevention activities working in close partnership with local commissioners and service providers.
- PHE will support partners, including commissioners and providers of health and social care, in the **development of care pathways** which account for the movement of people **around the detention estate** and **between prescribed detention settings and the community.**

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NHS and PHE Resources for Offender Health

- **The NHSCB is structured with a national team, 4 regions and 27 Area Teams (ATs).**
  - **Nine ATs and a regional team for London** have been designated to support commissioning of preventive and public health services as set out in the Section 7a agreement with SoS, in respect of persons detained in prison, or in other secure accommodation.
  - The ATs and London regional team will work with the NHSCB national team.
- **PHE also has a dedicated resource to support work on understanding and managing the health needs of people in contact with the criminal justice system.**
  - The national team sits within the Health and Wellbeing Directorate;
  - Ten **Offender Health Public Health Specialists** (Band 8c/d) are based in Public Health England Centres, working in the Operations Directorate, and 'man-marking' the ten NHSCB AT Offender Health 'leads',
  - These resources within both NHSCB and PHE at national and local level allow for **effective horizontal and vertical integration within organisations and between organisations.**

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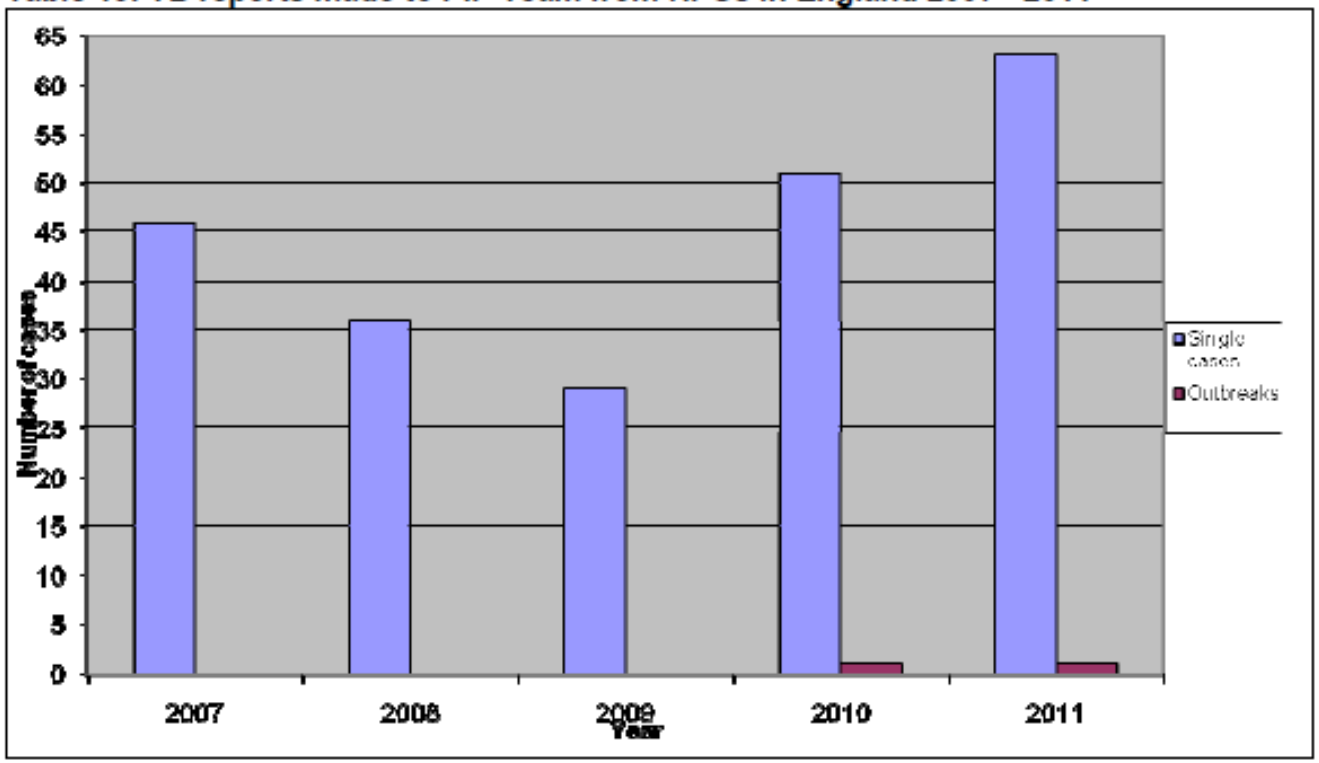
TB: A Case in Point

Table 13: TB reports made to PIP Team from HPUs in England 2007 - 2011



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TB, homelessness & prisons*.

•Levels of imprisonment, drug use and homelessness are high in London with an estimated 10,000 single homeless people living on the streets or in hostels, 70,000 problem drug users and over 5,000 prisoners at any one time.

•A **cohort study** was undertaken of **all patients with TB living in London** who **were or should have been on treatment** on **1 July, 2003**. Nearly 2,000 eligible patients were included giving an overall point prevalence of **27 per 100,000.**

•The **prevalence of TB among risk groups**:

- **788** per 100,000 in the **homeless;**
- **354** per 100,000 **in problem drug users;**
- **208** per 100,000 in **prisoners.**

*Tuberculosis in London: the importance of homelessness, problem drug use and prison. A Story, S Murad, W Roberts, M Verheyen, A C Hayward, for the London Tuberculosis Nurses Network

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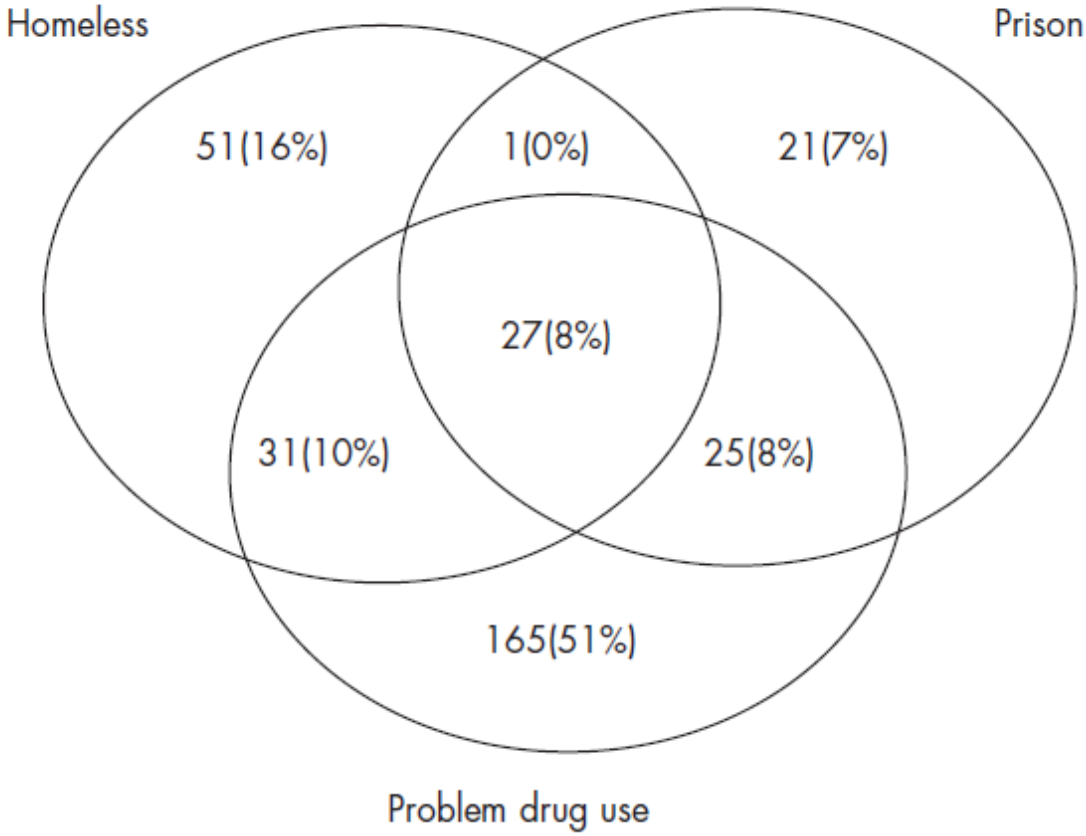

Figure 2 Overlap between prisoners, drug users and homeless people among patients with tuberculosis in London (not to scale).

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Public Health risk

- This study shows that **TB is a major public health problem in London**, and particularly among **homeless people, prisoners & problem drug users.**
- These patients have a **high prevalence of disease** and are **often infectious**, **drug resistant, poorly adherent and lost to follow-up**.
- Although forming less than 20% of all patients **they contributed nearly half of all drug resistant smear positive patients**, making a disproportionate impact on control.

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DOT, DOT, DOT!

- In London, in 2003 **only 12%** of homeless patients started their treatment under DOT but **a further 47% were later switched to DOT** after demonstrating poor adherence.
- **Similar figures were seen for prisoners and problem drug users.**
- This is despite NICE guidance that **DOT should be considered for people with TB in these risk groups.**

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Lost to follow-up?

- One of the challenges facing prison-initiated treatment programmes is **continuity of care in the community;**
- Most **TB treatment** regimens are **about six months** long but most periods of incarceration are less than this (between **3-6 months**).
- Many prisoners are discharged into **uncertain social circumstances-** homelessness, or temporary and insecure accommodation is common.
- **Local authorities** have an important role in working with prisons to identify suitable accommodation for prisoners on discharge, especially those on treatment for infection, addiction or other chronic diseases.

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Conclusions

•Most people in prisons and other places of detention **spend only a fraction of their lives in prisons** and most of their lives in the community;

•They often **face severe and multiple health and social problems**, including homelessness or insecure accommodation;

•**The formation of PHE and the re-organisation of the NHS and Public Health services** gives us an opportunity to address these long-standing concerns;

•We need courage, imagination and vision but tackling public health problems among 'hard-to-reach' people in prisons could have significant **public health gains for the whole community**.