New arrangements for prison health care

Provide an opportunity and a challenge for primary care trusts

From April, responsibility for prison health care in England has shifted from the Prison Service to primary care trusts. Under the new arrangements, primary care trusts are expected to develop prison healthcare delivery plans based on assessment and analyses of healthcare needs.¹ Given the extensive range of health problems reported among prisoners, this will be a major challenge for primary care trusts. Furthermore, in the light of the recent public health white paper, *Choosing Health*,² primary care trusts are expected to take a public health approach and aim to find the causes of health inequalities and social exclusion among prisoners and try and prevent them.

Health needs of prisoners are diverse and complex. Relative to the general population, they experience poorer physical, mental, and social health, including acute and longstanding physical and mental illness and disability, drug, alcohol, and tobacco dependency, sexual health problems, suicide and self harm, physical, psychological, and sexual violence, lower life expectancy, and breakdowns in family and other relationships.³⁻⁶ Moreover, prisoners are reported to be more preoccupied with their health and to place much greater demands on primary and secondary healthcare services than the general population.^{4, 7}

Recent research has highlighted three key areas where primary care trusts should prioritise resources—the staff who provide prison health care; the systems and structures of prisons, which influence the health of inmates and staff; and the health and social inequalities across the prison population.⁸

Prison healthcare services are undoubtedly served by highly committed professionals from different specialisms, professions, and agencies. Yet they commonly work under duress and challenging circumstances. Problems with recruitment, retention, and skills require urgent attention given the heavy reliance on temporary employees, particularly nurses and doctors, and erosion of the pool of permanent staff. Staff are often overstretched in their roles and performing beyond their ability or training—which is little incentive for newly qualified health professionals to take up a job in the prison system. Most health professionals do not encounter the prison system during their training.⁸ Such opportunities need to arise so that prisons begin to attract, recruit, and retain a healthcare workforce. Staff development, training, and career progression should then become a key priority for primary care trusts.

Structural factors also work against developing sound prison healthcare services. These include the standards of accommodation and facilities, the custody and control ethos of prisons, and cultural factors relating to staff and inmates. Managing change in these areas will be challenging since the shift of ownership and power over prison health care may be disempowering and unsettling for managers of the prison service and their employees.

Reorganisation provides a unique opportunity for reconfiguring prison health care by introducing more collaboration between services and developing a

public health approach to the organisation of prisons. But allegiance to public health principles that recognise the value of a healthy prison population means prioritising primary and secondary prevention and rehabilitation of offenders. This also requires a shift from crisis measures to upstream preventive measures, based on the principles of the World Health Organization of developing supportive environments for health.⁹ This implies action to ensure services are evidence driven, compassionate and supportive, focused on physical, mental, and social health needs of prisoners, and monitored effectively. The more traditional focus for public health intervention in prisons has been the promotion of healthy lifestyles. The need now is to develop measures that enhance opportunities for rehabilitation and which reorient structures, systems, services, and social arrangements in prisons.

Prison health care undoubtedly needs to change. The best interests of prisoners and the public will likely be served through stronger and more robust partnerships with agencies and interest groups outside prisons. Prisons are the last bastions of our welfare state to face modernisation, probably because society remains ambivalent about how to treat offenders and the purpose of imprisonment. Given that most imprisoned offenders are released after relatively short periods of confinement, custody would best serve the public by becoming supportive and empowering, thereby embracing public health principles and practices. This implies far reaching changes in the management of offenders, including possible reform of traditional imprisonment towards a more progressive system of custody. After all, the Prison Service is bound by a duty of care, “to look after prisoners with humanity.”¹⁰

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