Homelessness and Health;

Prisoner Health

"A humane society should be able to offer something of value even to those of its members with entrenched experiences of disenfranchisement."

Linda Seymour, Centre for Mental Health, July 2010.

"Future generations will look back on our generation which has criminalised a large section of its mentally ill as being just as misguided as previous generations which exhibited the mentally ill as freaks."

A Report from the All-Party Parliamentary Group on Prison Health

Stephanie Taylor

Contents

Abstract

Background

The UK has the highest number of prisoners in Western Europe and the prevalence is estimated to keep on rising. In 2006 the NHS completed its take over for providing healthcare to prisoners. Despite the ethos of the NHS, there are huge inequalities between healthcare for prisoners and the general population.

Aims

To learn about the main clinical problems of prisoners, their causes and their consequences.

To learn about current healthcare provision for prisoners and to explore changes and improvements that could be made to improve healthcare provision for prisoners

Method

Visits to HMP Styal, HMP Altcourse , HMP Kennet and Bunbury House Bail Hostel were undertaken. General internet searches were conducted as well as literature searches in various relevant search engines (e.g. MEDLINE).The literature obtained was compiled with information gained on prison visits to produce this report.

Results

The prevalence of mental health problems, substance misuse, suicide and self harm are extremely high amongst prisoners. There is also a higher prevalence of the physical consequences if drug use. Prisoners also have similar general health needs of any other human being.

Conclusion

There needs to be more strategies in place to reduce the risk factors for offending and identify those who are at risk of offending so that they can be diverted away from the criminal justice system and towards more relevant services. Improvements also need to be made for delivering healthcare to those currently in the criminal justice system so that it meets the standard of that of the general population and also focuses on the main clinical problems of prisoners.

Learning Objectives

- To understand the causes and consequences of being in prison and to be up to date with current literature in this area.
- To learn about the main clinical problems of prisoners.
- To explore the best ways to provide healthcare for prisoners in a sustainable fashion.

Acknowledgements

I would like to thank Siobhan Harkin for her emotional and administrative support during this SSM.
I would also like to thank Dr O'Neill and Dr Sutton for providing the opportunity to complete this SSM which provides a unique learning experience that would not otherwise be covered under current undergraduate curriculum.
Special thanks to the staff at HMP Styal, HMP Altcourse, HMP Kennet and Bunbury House Bail Hostel that gave up their time to answer my questions.
Finally, I would like to thank all the prisoners who kindly let me sit in on their consultations allowing me to gain first-hand insight into their healthcare needs.

Definitions

It is important to highlight some key terms:

Key Term	*Definition*
Health (WHO)	"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity[1]"
Human Rights	"The conditions and expectations to which every person, by virtue of his or her existence as a human being, is entitle[2]"
The inverse care law	"The availability of good medical care tends to vary inversely with the need for it in the population served[3]"
The poverty line (Britain)	"Households surviving on less than or equal to 60% of the median income are said to be living below the primary threshold of income poverty[4]"
Health inequalities	"The difference in health status or in the distribution of health determinants between different population groups[5]"
Legally Homeless (As defined by the 1996 housing act)	"A person is legally defined as homeless in England if: • There is no accommodation that they are entitled to occupy • They have accommodation but it is not reasonable for them to occupy this accommodation • They have accommodation but cannot secure entry to it • They have accommodation but it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where they are entitled or permitted both to place it and reside in it[6]"
Rough sleeper	"Those that sleep in the open air, or in other locations/buildings not meant for habitation (e.g. car parks, barns, train stations)[6]"
Substance misuse	"Intoxication by-or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes

	problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances[7]"
Harm reduction	"Harm reduction is a term that defines policies, programmes, services and actions that work to reduce the: • Health • Social and • Economic harms to: • individuals; • communities; and • society that are associated with the use of drugs[8]"
Asylum seeker	"Any person, who owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, owing to such fear, is unwilling to avail himself of the protection of that country[9]"
Post Traumatic Stress Disorder	"Post Traumatic Stress Disorder, PTSD, is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatene[10]"
Depression	"Depression is a common mental health disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentrarion[11]"
Drug related death	"Death where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971)[12]"
Suicide	"deliberate act of self-destruction[13]"
Domestic violence	"Any violence between current and former partners in an intimate relationship, wherever the violence occurs. The violence may include physical, sexual, emotional and financial abuse[14]"

Introduction

The National Health Service was launched in 1948 in the UK and it has grown to become the world's largest publicly funded health service. It was borne from the principle that "good healthcare should be available to ***ALL***, regardless of wealth[15]". It focused on 3 main ideals; it meets the needs of all, services are free at delivery and that it is based on clinical need, rather than the ability to pay[15]. As one can see the underlying principle is that of social *EQUALITY*.

> **"***Social equality* is a social state of affairs in which certain different people have the same status in a certain respect, at the very least in voting rights, freedom of speech and assembly, the extent of property rights as well as the access to education, health care and other social securities.[16]"

In July 2000 a modernization programme of the NHS added new principles in an attempt to reduce health inequalities, which included;

> **The NHS will respond to the different needs of different populations**; health services will continue to be funded nationally and be available to all citizens of the UK.
>
> **The NHS will help to keep people healthy and reduce health inequalities**; the NHS will try to prevent, as well as treat, ill health. It will recognise that health is affected by social, environmental and economic factors such as deprivation, housing, education and nutrition, and, with other public services, will intervene before as well as after ill-health occurs[15].

Unfortunately health inequalities in Britain persist today and it is important that we try our upmost to eradicate these inequalities, as inequalities challenge the ethical principle of justice, outlined by the Beauchamp and Childress principles of medical ethics.

Beauchamp and Childress' four principles of medical ethics[17];

- Respect for Autonomy: Respecting an autonomous individual's ability to make and act on their own decisions.
- Beneficence: Doing good to others. In a medical context this would mean acting in the patients best interests/to benefit the patient.
- Non-maleficence: Avoid causing harm to others
- Justice: Benefits, costs and risks should be distributed fairly.

The social determinants of health are mostly responsible for health inequalities[18]

Determinants of health;

- Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- Education – low education levels are linked with poor health, more stress and lower self-confidence.
- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- Health services - access and use of services that prevent and treat disease influences health
- Gender - Men and women suffer from different types of diseases at different ages[19].

Looking at the determinants of health it is easy to see why homeless people experience huge health inequalities.

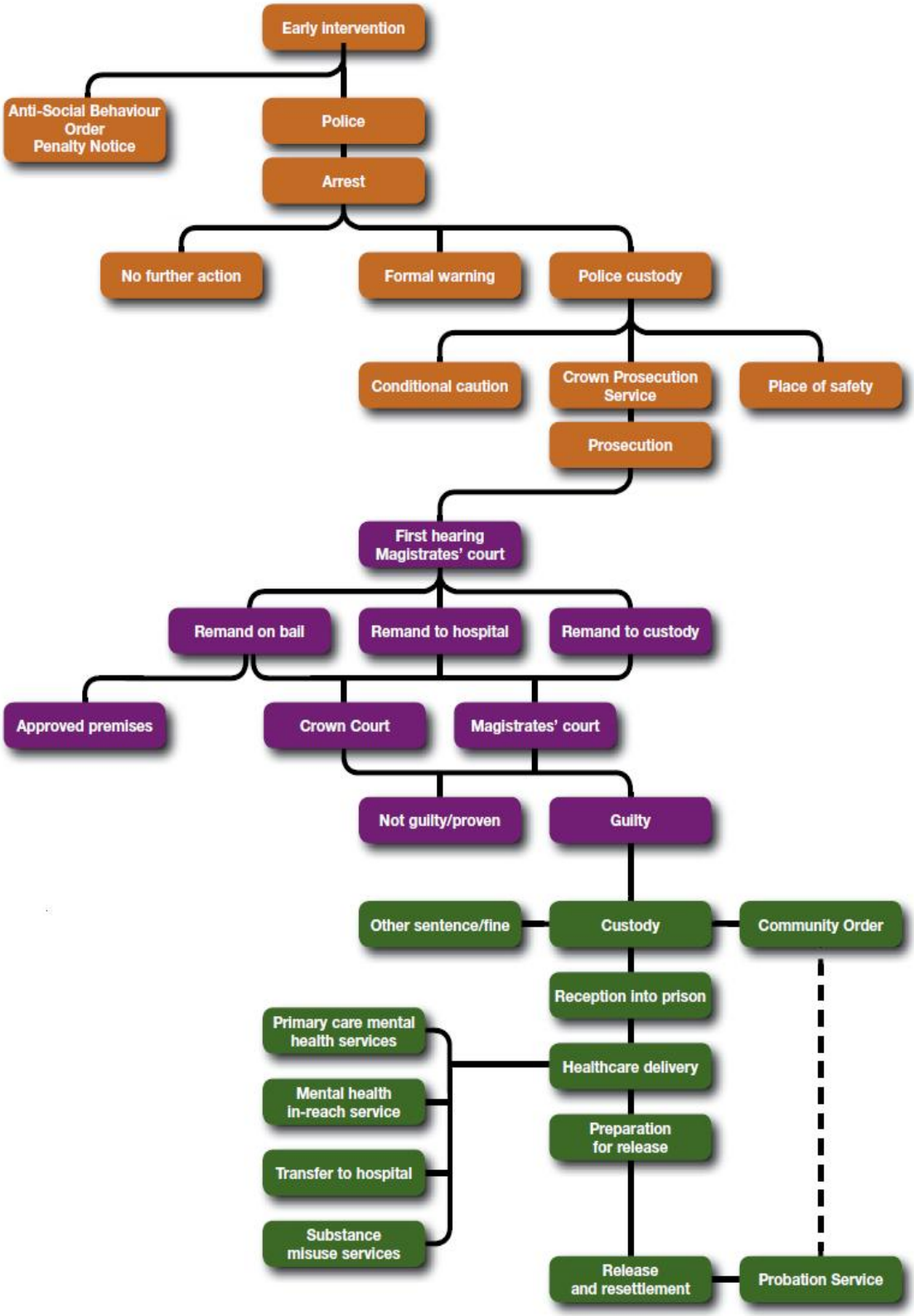
Homeless people suffer from higher levels of morbidity than the general population. This is due to multiple factors including a direct consequence of homelessness (malnutrition, poor personal hygiene, lack of shelter), substance misuse and its physical and psychological complications (including injecting drug use) and delayed access to healthcare.

A staggering 32% of the prison population is homeless compared to 0.9% of the general population[20] and surveys indicate 30% of people released from prison will have nowhere to live[21].

The focus of this report will be on Prisoner health.

The overall prison population in England and Wales on 12th July 2010 was 83001[21]. The projected prison population for 2013 is 106550, according to the Home Office[22]. The overall average resource cost per prisoner in England and Wales in 2007-08 was £39000[21].

Overview of the offender pathway[23]



There is a strong link between offending and social exclusion[23].

The nine key factors of social exclusion are;
-education;
-employment;
-drug and alcohol misuse;
-mental and physical health;
-attitudes and self-control;
-institutionalisation and life skills;
-housing;
-financial support and debt;
-family networks.

There are obvious similarities between the determinants of health and the key factors of social exclusion which lead to offending. Therefore, it is clear to see the strong link between offending and poor health.

The risk of someone becoming an offender starts early in life and increases due to a number of contributory factors including[20];
-Low maternal bonding
-Poor maternal mental health, Poor parenting skills
-Abusive home relationships
-Family history of involvement in the criminal justice system
-Learning difficulties
-Truancy and exclusion from school
-Poor educational achievement
-'Looked After' child status
-Conduct/emotional disorders

Social characteristics of prisoners compared to the general population[21];

Characteristic	*General population*	*Prison population*
Taken into care as a child	2%	27%
Regularly truanted from school	3%	30%
Excluded from school	2%	49% males, 33% females
No qualifications	15%	52% males, 71% females
Numeracy below level expected for an 11 year old	23%	65%
Reading ability below level expected for an 11 year old	21-23%	48%
Unemployed before imprisonment	5%	67%

Healthcare in Prison

Traditionally, healthcare in prison was provided by the prison service (part of the Home Office) the systems for quality control were not as rigorous as found in the NHS, and the standards of care varied hugely therefore following a joint publication by Department of Health and Prison Service report in 1999, there was a gradual handover of the responsibility to provide healthcare to inmates from the Prison Service (part of the Home Office) to the local Primary Care Trusts (part of the NHS). This was done in phases and was completed in April 2006[24].

Healthcare in prisons varies from prison to prison but it largely consists of;

- GP
- Psychiatrist
- Mental Health Nurses
- General Nurses
- Pharmacist
- Physiotherapist
- Podiatrist
- Dentist
- Optician
- Substance misuse specialist nurses
- Anticoagulation specialist nurse
- GU specialist nurse

All new prisoners are seen by a nurse on entering the prison and an initial medical questionnaire is completed. Any immediate physical or mental health problems, significant drug or alcohol problems or risk of suicide/self-harm are identified. If indicated, referrals can be made to chronic disease management clinics, immunisation clinics, GP appointment, mental health services and detoxification services. Prisoners not identified with immediate healthcare needs are offered a general health assessment within the week following reception[25].

Prisoners can request to see whichever healthcare professional they need and waiting times vary greatly between healthcare professionals and prisons.

Method

Information and literature was gathered from various sources;

- Visits to HMP Styal, HMP Altcourse, HMP Kennet and Bunbury House sitting in on clinics and speaking to staff allowed background knowledge to be gained on the key issues in prisoner healthcare.
- General internet searches were completed throughout the report
- The university of Liverpool and Fade Library were visited and searched for relevant literature.
- The Cochrane database and Bandolier secondary resources were accessed and searched for relevant literature.
- The lancet was searched for relevant literature.
- Separate electronic literature searches were conducted in MEDLINE, Cinahl, Psych info and EMBASE via the NHS search engine. Logical sequences of search terms were conducted using both MESH terms and natural language terms and exclusions were made relevant to language and dates to obtain the most relevant and up to date journal articles.

Please refer to Appendix 8 for an example of the search strategy performed.

Results

The key health problems of prisoners;

Mental Health;

72% of male and 70% of female prisoners suffer from two or more mental health disorders and 10% of men and 30% of women have had a previous psychiatric admission[21].

The main mental health problems in prison are;

- Learning difficulties; 20–30% of offenders have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system[21]. People with learning difficulties are at risk of being victimized and bullied whilst in prison. They are also unable to access prison information routinely and are therefore excluded from elements of the prison regime and this increases psychological problems.
- Personality Disorder; The prevalence of personality disorder amongst prisoners is 66% compared to 0.4% of the general population[20]
- Psychosis; The prevalence of psychosis amongst prisoners is 8% compared to 0.4% of the general population[20]
- Depression and anxiety; the prevalence of depression and anxiety problems amongst prisoners is 45% compared to 17.6% of the general population[20].
- Neurotic disorders; 40% of male and 63% of female prisoners have a neurotic disorder, over three times the level in the general population[21].

Suicide and self harm

In 2008, there were 24,686 recorded incidents of self-harm – 11,747 for men and 12,938 for women[21]. There were 60 apparent self-inflicted deaths in custody in England and Wales in 2009[21]**,** 20% of these deaths were in the first 7 days of admission to prison and there was a history of attempted suicide in 37% of these deaths.

Substance misuse;

The prevalence of drug dependency in the prison population is 45% compared to 3.4% of the general population[20]. Drug use amongst prisoners in custody remains high with opiates and cannabis being the most common.

The prevalence of alcohol dependency amongst prisoners is 30% compared to 5.9% of the general population[20]

75% of all prisoners have a dual diagnosis (mental health problems combined with alcohol or drug misuse)[21].

Physical health

Half of all those sentenced to custody are not registered with a GP prior to being sent to prison[21].

Prisoners have the same physical health needs as the general population.

Chronic diseases such as asthma, diabetes and hypertension need the same management inside prison as they do outside prison.

Prisoners are at increased risk for a wide variety of communicable diseases, including TB, HCV, HBV and HIV. Tattooing, piercing, and injecting drug use, remain commonplace in many prisons[26].

Prisoners are offered a sexual health screen at reception into prison.

Also, physical problems relating to injecting drug use are common with DVTs and leg ulcers being particularly common amongst prisoners.

Literature review

For my literature review I chose to review an article entitled *"Public health and criminal justice; Promoting and protecting offenders' mental health and wellbeing*[20]*"* by Linda Seymour, Centre for Mental Health, July 2010. This paper identifies the similarities between the risk factors of social exclusion, poor mental health and offending and suggests a range of interventions that reduce these risk factors.

Method used:

This paper examines the incidence of poor mental health among offenders, assesses the risk factors that influence their mental health and explores the possibilities for protection and promotion of their mental health.

Main findings:

- The incidence of poor mental health is high amongst offenders.
- Offender mental health is a critical public health issue.
- The social characteristics of offenders present a picture of deprivation and risk factors for poor physical and mental health and social exclusion.
- There is a strong correlation of risk factors for poor mental health, offending and social exclusion. Interventions that succeed in decreasing key risk factors for any one of these issues will have huge benefits both personal and social in reducing the others.
- Promoting and protecting the mental health and wellbeing of offenders and those at risk of offending can have wide-ranging benefits for individuals, their families and their communities.
- Interventions that focus only on individual factors such as health, to the exclusion of the broader landscape (housing, employment, education and social networks) will be unlikely to deliver the necessary change to turn their lives around.

It suggests:

Interventions can be made from primary, secondary and tertiary prevention strategies.

- Primary interventions may focus on enhancing protective factors (e.g. mental health promotion in schools and resilience training in adolescents).
- Secondary interventions would involve identifying those at high risk and diverting them away from the criminal justice system and into healthcare, social services, education, employment and housing.
- Tertiary interventions for those already in the criminal justice system might include creating healthy environments in prisons, providing education and employment and housing on leaving prison. Acutely ill prisoners should be given appropriate care and treatment in the right medical setting.

It concludes:

Tackling health inequalities is the key to decreasing offending and social exclusion will improve public health and overall will be less costly.

Recommendations:

- Collaborative working between public health and the criminal justice system is the key to delivering this agenda.
- Reinvesting to save will bring the greatest benefits; Money spent on building new prisons could be directed towards programmes to address offending risk factors and prevent offending from occurring.
- Utilize the learning from existing innovative practice to address the inter-related problems of offending, mental health, drug dependency and social exclusion.
- Use involvement with the criminal justice system as an opportunity to promote and protect mental health.
- Public discourse on offending and mental health is needed as public attitudes are sometimes skewered towards retribution alone.

Strengths and weaknesses

Strengths	*Weaknesses*
• Recent publication date makes the review up to date with the current situation. • Published by a charity with no financial incentives. • Clear, easy to read lay out, content and design. • The information in the report was fully referenced. • Results can be applied both locally and nationally. • Primary, secondary and tertiary interventions were suggested to fully tackle the problem	• Author may be bias. Linda Seymour had previously worked for Sainsbury Centre for mental health; they have produced many reports on the topic which were cited throughout this report. • Many of the suggested interventions were based on small trials or pilot schemes so their validity may be questionable. • The paper develops from discussions raised by an American public health official, thus may not be relevant to the UK.

Limitations and areas for future study;

The report only briefly spoke about the issues surrounding the high percentage of minority ethnic groups and foreign nationals. I would like to see a more in-depth discussion about the differences of risk factors for poor mental health in this group of people and suggested interventions to help.

It only briefly mentioned the mental health differences between men and women in the criminal justice system and the implications for women in prison on the family unit and the consequences on her children. Further areas of study could focus on secondary and tertiary intervention programmes for women who have children.

The health of people aged over 60 was also only briefly mentioned; I would like to see a more in-depth discussion and suggested interventions for this group of people.

Discussion

The main issue when evaluating the current services in prisons across the UK is that there is a huge variation between prisons which is made worse by the fact that prisoners are often frequently transferred between prisons.

Continuity of care is a major issue both on arriving at prison and on release. It is not standard that health records are requested for every inmate. This is not helped by the fact that half of all prisoners are not registered with a GP[27]. Once a person is released from prison, health records are not routinely sent to their GP and only if the GP specifically requests the information will they receive it. It is therefore clear to see how the resettlement needs of prisoners with mental health problems are not being met[21].

The quality of care is also questionable as some doctors who work in prisons do not specifically want to work inside a prison. There is also a high percentage of locum GPs and Psychiatrists who work in prisons which raises further issues regarding continuity of care.

Services for physical health problems are standard between prisons but prisoners often find that waiting times are long and some may have problems filling out the relevant application forms. Also, visits outside the prison to specialists are problematic and are often cancelled due to staff shortages.

Mental health services in prisons can be split into general mental health services, substance misuse services and suicide/self harm services which often overlap with each other.

General mental health services;

Consist of psychiatrists, primary care mental health nurses and mental health in-reach teams. Treatment for mental health problems is usually drug based as availability of psychotherapies are limited in the prison setting.

Suicide and self harm services;

The safer custody team are involved with prisoners who have attempted or contemplating self harm/suicide. An ACCT plan is initiated which states that vulnerable prisoners are checked on at least 5 times every hour and a CAREMAP is completed. This aims to address the problems behind self harm and find ways of coping that does not involve self harm.

High risk groups for suicide:
Lifer, IPP sentence, licence recall, failed appellants, offenders charged with murder, offenders sentenced to 10 years or more, offenders remanded for serious offences that carry a large sentence, offenders charged with domestic violence and foreign nationals awaiting deportation.

Substance misuse;

The integrated drug treatment service (IDTS) offers a treatment regime of methadone maintenance for people who are addicted to heroin. When new prisoners arrive they can only be initiated on their community dose of methadone if they have been taking it under supervision in the community. If not, they have to be stepped up gradually and this is often not welcomed by the prisoners as they often feel terrible and have sleeping problem during this period. People are reviewed and given the opportunity to step-down their methadone or attend a detoxification program.

CARAT (Counselling, Assessment, Referral, Advice and Throughcare) carries out much of the substance misuse work.

The objectives of the CARAT team[28];

- Identify prisoners with substance misuse problems and asses their needs.
- Provide accurate information on drugs and the harmful consequences of using them.
- Help drug misusers access services and rehabilitation programmes, and inform them about the range of choices available.
- Contribute to the case management of those who are serving custodial sentences and to liaise with appropriate services
- Help implement an effective care plan that can realistically respond to the needs of the drug misuser.
- Liaise with outside prison agencies as the prisoner prepares to leave. This is predominantly with the Drug Intervention Programme (DIP), which takes care of a prisoner with substance misuse issues facing release.

Some prisons offer rehabilitation programmes for prisoners wanting to tackle their drug problem. The programmes offered vary widely and can last a few weeks or up to 18 months[29].

Examples of rehabilitation programmes available in prison include;

FOCUS and Short Duration Programme (SDP), both are based on cognitive behavioural therapy techniques.

Unfortunately the chances of prisoners continuing on drugs programmes on release are very slim as prisoners are often viewed as 'new cases' when they are released and have to join the back of the queue[21].

Despite the high prevalence of alcohol misuse amongst prisoners, a considerable number of prisons have no alcohol strategy and where strategies exist they are often inadequate[21].

The RAPt Alcohol Dependency Treatment Programme gained accreditation in 2008, post treatment, 77% of participants rated their risk of relapse as either low or very low[30]. This scheme is currently run in only one prison in the UK.

Counselling

Counselling services in prison vary and waiting times to see qualified counsellors can be long.

Some prisons offer a free phone line to the Samaritans or MIND and prisoners can contact these agencies when they are able to use the telephone.

Unfortunately, this is usually during association time where there can be long queues to use the phone and the telephones are usually not in private places.

Chaplaincy services are offered in UK prisons and offer general counselling to the prisoners who request it.

Some prisons have inmates who volunteer to attend a counselling course. These inmates are then called Carers or Listeners and other inmates can approach them and discuss their problems with them.

So far, this discussion has focussed on the current tertiary prevention services available in prisons in the UK.

What has become obvious throughout this report is that there needs to be increased financial input into primary and secondary prevention services as well as improvements in tertiary prevention services.

Approaches should focus on reducing/eliminating risk factors for offending. This can be achieved by:

- Strengthening individuals; by increasing emotional resilience, increasing self-esteem, teaching life and coping skills such as communication, relationship building and parenting skills.
- Strengthening communities; by increasing social inclusion/participation, improving neighbourhood environments, developing health and social services that support mental health.
- Promoting enabling structures; that support mental health by reducing discrimination and inequalities, promoting access to education, meaningful employment, housing and support for everyone, in particular those who are most vulnerable.

Conclusion

Mental health problems are extremely prevalent amongst the offending population. The reason for this has become clear; there is a huge overlap between the risk factors for poor mental health, offending and social exclusion and poor mental health is intertwined with offending.

As a society we need to do all that we can to promote and protect the mental health of offenders and those at risk of offending. This would have huge benefits for individuals, their families and communities and society as a whole. Early intervention strategies before those at risk enter the criminal justice system will undoubtedly reap health, social and financial returns.

Future interventions need to be holistic and aim to improve both the health and social circumstances of people at risk of offending.

Recommendations

- More needs to be done to reduce the risk factors for offending and this would prevent much of the offending from occurring in the first instance. This would improve the mental health of the public and lead to less substance misuse problems. There needs to be strategies in place that identifies those people at risk of offending. These people can then be diverted away from the criminal justice system and towards more appropriate agencies where they would get the help they need for any mental health problems and social support.
- Improvements in healthcare are needed for those already in the criminal justice system. Healthcare in prisons has improved over the last decade but it still does not meet the standards of healthcare of the general population. This can be achieved by emphasizing the importance of continuity of care both on entering prison and on leaving prison, improving the quality of care and increasing the number of staff available.
- Increased support is needed once a person has left prison. This support needs to be holistic and include any on-going mental health needs or rehabilitation programmes, housing, education and meaningful employment; this will reduce the likelihood of reoffending.

Reflection

Completing this SSM has bee a valuable learning experience in a topic that was of particular interest to me.

I found the experience of being ‘excluded’ from HMP Styal very stressful. I was worried that I was not going to learn as much from the overall placement as I wanted to and felt necessary in order to complete this report.

However, using the overall experience from HMP Styal and the time already spent there before being ‘excluded’ along with all the information gained from HMP Altcourse, HMP Kennet and Bunbury House Bail Hostel, I felt more than equipped to complete this report.

I have learnt a great deal about the prison system, prisoner health and the risk factors for offending.

I feel passionate about helping this vulnerable group of people throughout my future career and hope that one day the Government implement the changes necessary in society to fully eradicate health inequalities.

References

1, World Health Organization. *WHO definition of health*. April 1948. http://www.who.int/about/definition/en/print.html (accessed 27 July 2010)

2, United Nations. *Universal Declaration of Human Rights*. General assembly, December 1948. http://www.un.org/en/documents/udhr/index.shtml (accessed 27 July 2010).

3, Hart JT. *The inverse care law*. The Lancet. 1971; 1(7696): 405-12.

4, The Poverty Site. *Choices of low income threshold.* http://www.poverty.org.uk/summary/income%20intro.shtml (accessed 27 July 2010).

5, The World Health Organization. *Health impact assessment-Glossary of terms used, F-P*. http://www.who.int/hia/about/glos/en/index1.html (July 26th 2010).

6, OSW (Off the streets and Into Work). *Homelessness Statistics*. Updated: 2009. http://www.osw.org.uk/info/statistics.asp (cited 2010 July 27).

7, National Institute for health and Clinical Excellence. *Community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people.* London: National Institute for Health and Clinical Excellence, 2007.

8, UKHRA (UK Harm reduction Alliance). *Harm Reduction Defined.* http://www.ukhra.org/harm_reduction_definition.html (accessed 26 July 2010).

9, The United Nations. *1951 Refugee Convention (article 1)*. Adopted by the United Nations Conference of Plenipoentiaries on the Staus of Refugees and Stateless persons convened under General Assembly Resolution 429 (v). December 1950.

10, National Institute of Mental Health. *Post-Traumatic Stress Disorder (PTSD*). Updated: May 2010. http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml (accessed 27 July 2010).

11, The World Health Organization. *Depression*. http://www.who.int/mental_health/management/depression/definition/en/ (accessed 27 July 2010).

12, Office for National Statistics. *Health statistic quarterly No.31*. London: Office for National Statistics. 2006.

13, Oxford Concise Medical Dictionary. 7th ed. Oxford: Oxford University Press: 2007, p690.
14, Home Office. *Violent crime, domestic violence mini site (definitions and statistics).* Updated: 2002. http://www.crimereduction.homeoffice.gov.uk/violentcrime/dv03.htm#4 (accessed 27 July 2010).
15, NHS Choices. *About the NHS.* Updated: 23 March 2009. http://www.nhs.uk/nhsengland/thenhs/about/pages/nhscoreprinciples.aspx (accessed 27 July 2010).
16, Babylon. *Definition of social Equality.* http://dictionary.babylon.com/social%20equality/ (accessed 26 July 2010).
17, Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 5ht ed. Oxford: Oxford University Press, 2001.
18, World Health Organization. *Social Determinants of Health.* http://www.who.int/social_determinants/en/ (accessed 27 July 2010).
19, World Health Organization. *The determinants of health.* http://www.who.int/hia/evidence/doh/en/ (accessed 27 July 2010).
20, Centre for Mental Health. *Public health and criminal justice; promoting and protecting offenders' mental health and well being.* Seymour L, July 2010. http://www.centreformentalhealth.org.uk/pdfs/Public_health_and_criminal_justice.pdf (accessed 20 July).
21, Prison Reform Trust. *Bromley Briefings; Prison Factfile.* June 2009. http://www.prisonreformtrust.org.uk/uploads/documents/june2009factfile.pdf (accessed 29 July 2010).
22, Prison Reform Trust. *Prison Facts; Number 64.* http://www.prisonreformtrust.org.uk/?id=1&fact=64 (accessed 21 July 2010).
23, The Bradley Report. *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* April 2009. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf (accessed 20 July 2010).
24, Public Healthy. *Prison Health.* http://www.publichealthy.com/prisonhealth.htm (accesed 23 July 2010).

25, HM Prison service. *Health Services for Prisoners.* May 2004. http://www.hmprisonservice.gov.uk/assets/documents/10000305_22HealthServicesforPrisoners.pdf (accessed 26 July 2010).
26, The Lancet. *Putting policy into practice on prison health.* August 2007, vol 7, p497. http://download.thelancet.com/pdfs/journals/laninf/PIIS1473309907701627.pdf (accessed 26 July 2010).
27, Prison Reform Trust. *Prison facts; number 68.* http://www.prisonreformtrust.org.uk/?id=1&fact=68 (accessed 21 July 2010).
28, The rehabilitation Action for Addicted Prisoners Trust. *RAPt CARAT Teams.* http://www.rapt.org.uk/page.asp?section=83&sectionTitle=RAPt+CARAT+Teams (accessed 27 July 2010).
29, HM Prison Service. *Addiction advice.* http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/addictionadvice/ (accessed 26 July 2010).
30, National Offender Management Service. *Interventions and Substance Misuse News.* June 2009, issue 1, p7.

Appendix 1; Good Medical Practice: Duties of a doctor

The ***duties of a doctor*** registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
    - Keep your professional knowledge and skills up to date
    - Recognise and work within the limits of your competence
    - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
    - Treat patients politely and considerately
    - Respect patients' right to confidentiality
- Work in partnership with patients
    - Listen to patients and respond to their concerns and preferences
    - Give patients the information they want or need in a way they can understand
    - Respect patients' right to reach decisions with you about their treatment and care
    - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
    - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
    - Never discriminate unfairly against patients or colleagues
    - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions

Appendix 2: Media portrayal of prisoners

Daily Mail	***Daily Express***
• Foreign criminals leave jail and are living in £25,000-a-head centre instead of being deported (19/07/2010) • Prisoners given pedigree dog to stroke... to prevent them smashing up cells (24/04/2010) • Prisoners paid £27m in benefits while behind bars (26/03/2010) • Prisoners paid hundreds of pounds in unemployment benefits to sit in their cells (08/03/2010)	• TAXPAYERS are forking out more than £44million a year to maintain the drug habits of thousands of prisoners.... (01/06/2010) • PRISONERS who claimed their human rights had been violated cost taxpayers an amazing £22million last year. ... (07/06/2010) • PRISONERS: HOW THEY ARE TREATED LIKE PRIVATE PATIENTS; A MAXIMUM security jail is providing healthcare for inmates which far surpasses NHS treatment given to law-abiding members of the public, a report has found...(15/04/2010)
The Sun	***Daily Star***
• OVER 400k spent giving lags lessons in Indonesian drumming and other arty projects (17/03/2010) • Lags given 27,000 new TVs (03/02/2010) • Lags paid £500k in uni loophole (08/02/2008)	• Fussy ethnic minority jailbirds want more 'authentic' food (14/07/2010) • Jailed armed robber wants time out to sunbathe (13/06/2010) • Prisoners can study yoga and theatre (8/01/2010)

As one can see the media more often than not portrays an extremely negative picture of prisoners with an unsympathetic view that focuses on how much they are costing the taxpayer.

Appendix 3; Case Histories

Mr X is a 45 year old man currently on licence and residing in a bail hostel. His father had served prison sentences for armed robbery offences but he states that he was always good at school and gained employment on leaving school. His brothers were conducting armed robberies and he was jealous of their nice cars but it wasn't until he got made redundant that he gave in to the 'peer pressure' from his brothers and began to commit armed robberies himself.
He found it easy to do and slipped into the lifestyle. He soon had lots of money and properties all over the world where he lived abroad and returned to the UK only to commit more armed robberies to support his lifestyle.
Whilst he was living in South Africa he was caught by the British Authorities and extradited back to the UK where he was sentenced to 8 years in prison in 1994. In 1999, he escaped from prison and began committing more armed robberies until he was recaptured in 2001 and given a further 14 year sentence. Whilst in prison he attended Art classes, he states that he accidentally painted and found something he both enjoyed and was talented. He undertook an Art degree in an open prison which he states was very hard and he had to fight to be allowed to do it.
In 2009, he was released on licence and he found this a very scary experience as 'everything had changed'. He states that the Prison Service seemed against him and wanted him to fail. He states that if it wasn't for the support of his friends and family it would have been impossible to cope mentally, socially and financially. He said that there were no services both in and out of prison that would help him and found the probation service to be 'a waste of time'.
10 months later he was recalled from his licence and spent a further 6 months in prison but was then released without charge but his new licence stipulates that he resides at a northern bail hostel (he was living near his friends and family in the south). He states that being recalled was a terrible experience and feels that even though he is out of prison that his life is still 'on-hold' until his licence expires as 'his world could be turned upside down again at any given time'.
He currently has his art work on show in a London Art Gallery.

Miss X is a 23 year old woman currently serving a 4 year prison sentence.
She was in full time employment which she enjoyed but after a relationship breakdown she started to go out clubbing and take drugs.
She is from a good family but her parents live down South and she was quite isolated in Liverpool. Her parents bought her a new car and she was able to buy her own flat with money that her grandmother left her in her will.
She started to go out every night and take cocaine, within 12 months she had lost her job and had 7 convictions for drink driving, drunk and disorderly and possession of drugs.
She stopped going out so that she could save money to buy more drugs and she started to sleep with men for money. Around this time she started to self harm.
She got sentenced to 4 years in prison after agreeing to keep drugs at her home for a drug dealer for a small fee.
Whilst in prison she feels isolated from her friends anf family and feels that they are not doing enough to support her. Her self harm has increased dramatically and her mental health has deteriorated significantly.

Appendix 4; Suggested week long timetable template for prisoner health

	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
AM	Introduction to prison healthcare Tour of Prison	Shadow CARATS worker	Shadow psychiatrist	Ward round MDT reviews	Shadow ACCT worker (self harm monitoring and reduction)
PM	GP Clinic First night receptions	Shadow IDTS worker	Shadow In-reach mental health worker	Drop-in centre (housing/education/ employment/resettle-ment issues)	Sexual Health Nurse Clinic

Appendix 5: Presentation

Appendix 6; Resource list; Key Contacts

1, Siobhan Harkin, Global inclusion administrator, C18 Stanlaw Abbey Business Centre, Dover Drive, Ellesmere Port.
Telephone: 01513554008
Email: global.inclusion@yahoo.co.uk
2, Dr Joseph O'Neill, Convenor, Addaction, 83-93 Stonebridge Lane, Croxteth, Liverpool, L11 4SJ
Telephone: 07967370358
Email: global.inclusion@yahoo.co.uk
3, Dr Jean Sutton, Cornerstone surgery, Fingerpost Park Health Centre, St Helens, Wa9 1LN.
Telephone: 017444738835
Email: jean.sutton@hsthpct.nhs.uk
4, Dr Jimi Robinson, On-site doctor, HMP Styal, Wilmslow, Cheshire, SK9 4HR
Telephone: 01625553168
Email: James.Robinson@hmps.gsi.gov.uk
5, Dr Dawson, On-site doctor, HMP Altcourse, Brookfield Drive Fazakerley, Liverpool, L9 7WU
Telephone: 01515222000
6, Dr Naidoo, On-site doctor, HMP Kennet, Parkbourn, Maghull, Liverpool, L31 1HX 0151 213 3000
Telephone 01512133000
7, Dr Siva, On-site GP, Bunbury House Bail Hostel, Alnwick Drive, Ellesmere Port, Cheshire, CH 65 9HE
Telephone 01513573551
8, Ian Jones, Probation Officer, Bunbury House Bail Hostel, Alnwick Drive, Ellesmere Port, Cheshire, CH 65 9HE
Telephone 01513573551
9, Kieran Lamb, Head of Library Services, Fade Library, Regatta Place, summers Road, Brunswick Business Park, Liverpool, L3 4BL
Telephone: 01512854495
Email: kieran.lamb@fade.nhs.uk

10, Phil Clark, Support Worker, 103 Drop-in Centre, Church Road, St Helens, WA10 1AJ
Telephone: 0174420032

Appendix 7; Resource List; Websites

1, Prison Reform Trust;
http://www.prisonreformtrust.org.uk/
2, Department of Health Offender Health;
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Offenderhealth/index.htm
3, HMP Prison Service;
http://www.hmprisonservice.gov.uk/
4, Offender Health Research Network;
http://www.ohrn.nhs.uk/
5, The Bradley Report; A review of people with mental health problems or learning disabilities in the criminal justice system;
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf
6, Bromley Briefings Prison Factfile;
http://www.prisonreformtrust.org.uk/uploads/documents/june2009factfile.pdf
7, The Corston Report; a review of women with particular vulnerabilities in the criminal justice system
http://www.banksr.com/other_documents/Corston_Report_Part_1.pdf
8, Nacro: The mental Health Problem in UK prisons;
http://www.nacro.org.uk/data/files/nacro-2006110801-352.pdf
9, Centre for Mental Health: Public Health and Criminal Justice;
http://www.centreformentalhealth.org.uk/pdfs/Public_health_and_criminal_justice.pdf
10, National Treatment Agency for substance Misuse;
http://www.nta.nhs.uk/criminal-justice.aspx

Appendix 8; Example of search strategy using MEDLINE search engine

No.	Database	Search term	Hits
1	MEDLINE	prisoner.ti	275
2	MEDLINE	offender.ti,ab	1739
3	MEDLINE	offender.ti	589
4	MEDLINE	health.ti	326999
5	MEDLINE	1 AND 3	0
6	MEDLINE	4 AND 5	0
7	MEDLINE	1 OR 3	864
8	MEDLINE	4 AND 7	32
9	MEDLINE	drug.ti	152643
10	MEDLINE	8 AND 9	0
11	MEDLINE	mental.ti,ab	156312
12	MEDLINE	8 AND 11	12
13	MEDLINE	women.ti,ab	513510
14	MEDLINE	8 AND 13	1

Appendix 9; Timetable

Week 1					
	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
AM	Introduction	Convenor review	103 Day centre, St Helens	Background reseacrch	Background research
PM	Visits to Sure Start Stoke House Autism Residential	Addaction talk; Heroin	Homelessness clinic, Dr Sutton	Visit to FADE Library to renew Athens account	Background reading

Week 2					
	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
AM	HMP Styal	HMP Styal	Contact CIB	Ex-prisoner case hitory	HMP Kennet
PM	HMP Styal	Background reading	Background reading	Bunbury House	HMP Kennet

Week 3					
	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
AM	HMP Altcourse	Prepare presentation	Draft introduction	Conduct literature searches	Presentation to Dr O' Neill
PM	HMP Altcourse	Plan write up	Complete introduction	Presentation to Dr Sutton	Draft method

Week 4					
	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
AM	Complete results Section	Complete literature review	Draft conclusion/ recommendations	Overall formatting and references	Hand in final draft
PM	Complete case history writ up	Complete Discussion	Complete appendices, timetable and abstract	Print and bind	