ORGANIZATIONAL MODELS OF PRISON HEALTH

CONSIDERATIONS FOR BETTER GOVERNANCE

Abstract

There is currently a variety of models of prison health accountability across the WHO European Region. The WHO Regional Office for Europe recommends that leadership should come from health ministries if health equity between prisons and the outside community is to be achieved. Most importantly, a whole-of-government approach is required to improve the quality of health services in prisons. This policy brief describes the governance and organizational models for prison health adopted by three European countries – Finland, Portugal and England. Each of these has a different arrangement in place, either under the Ministry of Health or under the Ministry of Justice working in partnership with the Ministry of Health. Those that have undergone a change in governance model have done so at different moments and adopted a different approach to implementing the change. Each of the three countries is considered separately, then similarities and differences between them are highlighted. Finally, recommendations are given for countries considering making a transition in the governance model that will improve the health services provided and the health status of people in prison.

Keywords

PRISONS
PRISONERS
GLOBAL HEALTH
PUBLIC HEALTH
HEALTH SERVICES
HEALTH POLICY
HEALTH SERVICES ACCESSIBILITY
RIGHT TO HEALTH
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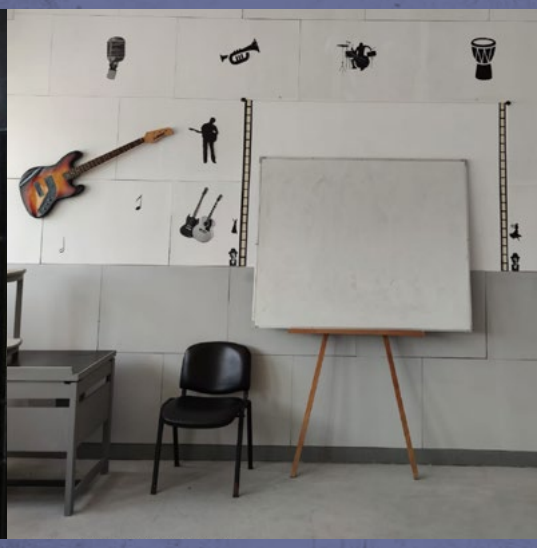
Abbreviations

ART	antiretroviral therapy
AVI	Regional State Administrative Agency (Finland)
CCGCS	Centre of Competencies for the Management of Health Care(Portugal)
DGRSP	Directorate-General of Prison and Reintegration Services (Direção Geral de Reinserção e Serviços Prisionais) (Portugal)
DHSC	Department of Health and Social Care (United Kingdom)
DSS	Direction of Health Services (Portugal)
GP	general practitioner
HBV	hepatitis B virus
HCV	hepatitis C virus
HMPPS	Her Majesty's Prison and Probation Service (United Kingdom)
INSA	National Health Institute Dr Ricardo Jorge (Instituto Nacional de Saúde Doutor Ricardo Jorge) (Portugal)
LGBTQ	lesbian, gay, bisexual, transgender and queer
NCD	noncommunicable disease
NICE	National Institute for Health and Care Excellence (United Kingdom)
NHS	National Health Service (United Kingdom)
OST	opioid substitution therapy
P-NHS	Portuguese National Health System
PHE	Public Health England
SPMS	Shared Services of the Ministry of Health (Serviços Partilhados do Ministério da Saúde) (Portugal)
TB	tuberculosis
THL	Finnish Institute for Health and Welfare (Terveyden ja hyvinvoinnin laitos)
VTH	Unit for Prisoners' Health Services (Vankiterveydenhuollon yksikkö) (Finland)



1. Background

Since 2013, as set out in the policy brief *Good governance for prison health in the 21st century*, WHO and partners have recognized that states have a special, sovereign duty of care for people in prison *(1)*. Furthermore, states are accountable for all avoidable health impairments to people in prison that are caused by inadequate health-care measures or inadequate prison conditions with respect to hygiene, catering, space, heating, lighting, ventilation, physical activity and social contacts. This implies that prison health services should maintain professional, ethical and technical standards that are at least equivalent to those applying to public health services in the community. Prison health services should also be provided exclusively for the care of people in prison – health-care staff must never be involved in the punishment of people in prison; they should be fully independent of prison administrations and yet liaise effectively with them; and they should be integrated into national health policies and systems, including the training and professional development of health-care staff.

Moreover, in support of the European policy for health, Health 2020 *(2)*, and the recommendations of the Council of Europe on prison health *(3)*, the Expert Group authoring the policy brief concluded that the management and coordination of all relevant agencies and resources contributing to the health and well-being of people in prison is a whole-of-government responsibility; and that health ministries should provide and be accountable for health-care services in prisons and advocate healthy prison conditions.

Progressively, some countries in the WHO European Region have initiated the transition of the governance of prison health from justice ministry to health ministry using various approaches. These include:

- adopting a gradual approach in different administrative regions or areas;
- investing in longer-term preparation to collect baseline data, before and after transition, that could reveal the impact of such changes;
- adapting governance recommendations to mixed models with shared responsibilities between the justice and health ministries, with room for specific local arrangements according to the particularities of the health-care system, culture and socioeconomic background of the country.

This report provides three examples of governance arrangements for prison health care in the WHO European Region. Finland, Portugal and England are used to demonstrate how different models were implemented and to illustrate the advantages and challenges of each of the paths chosen. For each country, the main governance features and underlying organizational aspects are presented using the same structure. At the end, the similarities between the countries are highlighted and used as a basis to give recommendations that will assist other countries that are considering transferring responsibility for prison health care from justice ministry to health ministry or health care-related departments.

2. Finland

2.1 General presentation of prison and health-care system

The Finnish health system is based on public health-care services to which every resident is entitled. According to the Finnish constitution, public authorities must provide adequate social and health services for everyone. In addition, there are numerous private health services in Finland. In addition to the public health providers, there are numerous private health service providers in Finland. The Government's aims include maintaining and improving people's health, wellbeing and work and functional capacity as well as to reduce health inequalities.

2.1.1 Main actors

In Finland, prison health services are organized and funded by the Government of Finland and provided by the Unit for Prisoners' Health Services (VTH). VTH is an independent entity under the Finnish Institute for Health and Welfare (THL), which in turn is under the Ministry of Social Affairs and Health. All VTH's outpatient clinics and hospitals operate in prison premises. The prison system is managed and operated by the Criminal Sanctions Agency, which operates under the Ministry of Justice.

2.1.2 Coordination between the main actors

VTH is an autonomous juridical/legal actor which has its own annual budget, staff, rules of procedure, and Board. Its rules of procedure are compatible with those of THL. VTH recruits its own staff and acts as their employer in all aspects. The Board consists of members from the Ministry of Social Affairs and Health and the Ministry of Justice, the Criminal Sanctions Agency, THL, public health and social welfare institutions, and the NGO (nongovernmental organization) sector. The Board's aim is to become essentially an advisory body, rather than the decision-making body it is at present. THL nominates Board members every fourth year by invitation. VTH has its own internal management group consisting of senior management officers. It devises its own annual budget and work plan as well as its operational objectives; these are then negotiated with THL and given final approval by the Board.

THL has a legal responsibility to steer VTH and ensure that it meets its set goals and objectives within its financial framework and operates according to the law. THL supports VTH's efforts to develop its performance and efficiency as well as its cooperation with all relevant actors, including those at ministerial level and THL's wider research community. THL recruits, selects and appoints the VTH director and acts as their supervisor. The VTH director reports on a regular basis to THL and the VTH Board, and THL in turn reports to and negotiates with the Ministry of Social Affairs and Health on prisoners' health management and operations, as well as on its budgetary requirements. THL holds regular talks with the Criminal Sanctions Agency on the developments of VTH's operational environment. VTH

does not have its own administrative staff, so there is a cooperation agreement with several THL administrative units to provide the required administrative support, including (among other things) financial management, accounting, human resources development, and information and communication technology. Major investments are planned and managed in conjunction with THL. VTH's budget is negotiated as part of the Ministry of Social Affairs and Health package, so – at government level – prisoners' health is part of that ministry's budget portfolio. In THL, prison health matters fall within the portfolio of the department responsible for social and health services provided and managed by the government.

The strategic tripartite negotiations between THL, the Criminal Sanctions Agency and VTH at director-general level are conducted twice a year. The agenda for these meetings is agreed mutually and decisions taken at the meetings guide the cooperation between the parties.

At prison level, VTH coordinates its activities with local prison management and staff on a semiregular basis. VTH's goal is to have cooperative meetings between prison health-care units spread out across all the major geographical regions. Ideally, the meetings should be held at least twice a year, but in some regions cooperative arrangements are still under development..

Organizational supervision is provided by Valvira – the National Supervisory Authority for Welfare and Health – and the Regional State Administrative Agency, as a part of the Finnish regulatory system. Valvira supervises and guides health-care professionals and medical facilities in both private and public sectors. Through its supervision and guidance, Valvira ensures that the services provided by different health-care professionals and medical facilities are adequate. Supervision of health care is divided into four areas:

- ex-post (retrospective) monitoring of individual cases (for example, handling patient complaints after serious treatment failures);
- plan-based supervision (supervision following national or municipal health-care supervision plans or internal supervision of medical facilities);
- guidance and standards for health-care professionals and medical facilities; and
- issue of requested statements consisting of official documents to other authorities and courts of justice (including medical statements on causality of injuries for use of insurance officers).

The Regional State Administrative Agency (AVI) is the regional authority in charge of directing, licensing and overseeing health care. The aim of AVI is to ensure that high-quality health-care services are available for all residents. AVI directs and oversees health-care services, including public health services, provided by private actors. It also supports the work carried out by the municipality, joint municipal authorities and other actors to promote the health of people in the region. AVI's activities in the field of health care are informed by the legislation, instructions

from the Ministry of Social Affairs and Health, and cooperation with other actors, including Valvira and THL. AVI's tasks include:

- direction and oversight of health-care services
- granting licences to private health-care service providers
- supervising health-care professionals
- quality management
- handling complaints
- discretionary and specified government transfers.

2.1.3 Historical perspectives

VTH was re-established at the beginning of 2016 as part of the THL group. Before that, prison health care was organized by the Criminal Sanctions Agency, and services were grouped as a unit within the Agency. In early 2010 it was decided by the Ministers of Justice and of Social Affairs and Health that there was a need and justification for transferring the services and making them part of the public health-care system. It was decided that the services would be covered by the national government's budget and responsibility for their supervision given to THL. While the discussions were lengthy, the transfer itself was very quick, lasting only around six months. The transfer was conducted in the form of a cooperation project with a dedicated transfer budget, work plan, personnel, management and reporting structure.

The transfer was based on institutionalization of prison health services within the public health system and on implementation of the principle of normality within the services; the aim was to ensure that people in prison and VTH staff benefit from the latest developments and research results in the sector and the standard public sector supervisory services provided by Valvira and AVI.

2.2 Characteristics of prisons and people in prison

The Finnish prison system has two types of prison – closed, high-security prisons (70% of prison places) and open prisons (30%). Altogether, the Criminal Sanctions Agency has 26 prisons distributed throughout the country. People who are deemed to be better suited to less restrictive conditions than those available in closed prisons are placed in open institutions. Males and females are placed in separate accommodation wards in prisons. A new, very modern and carefully designed closed prison for females only is due to open in October 2020.

In 2017, according to Criminal Sanctions Agency statistics, the average daily number of people in prison was 3035, which was 3% lower than the previous year. The official capacity of prisons recorded in 2016 was 3079 *(4)*; assuming the capacity remained unchanged, the occupancy level for 2017 was estimated at 98.4%. Unsentenced (remand) people in prison represented 19.7%; and of those sentenced, 195 were life sentences (6.4% of the total), with an average length of incarceration of 14 years.

The prison population statistics for 2017 show the number of foreign people in prison to be 540, corresponding to 18% of the total prison population, with 69

different nationalities represented, the most frequent being Estonian, Iraqi and Romanian. The share of females in prison is among the highest in Europe, with 198 incarcerated women in 2017 *(4)*. The most recent figures (2019) indicate that young people in prison (under 21 years) represented 1.8% of sentenced prisoners and 7.1% of remand prisoners. Older people in prison (over 59 years), also in 2019, represented 4.3% of sentenced prisoners and 3.9% of remand prisoners.

According to previous studies, the health of people in prison is noticeably worse than that of the general population, both for adults and for young adolescents *(5)*. Most people in prison suffer from various mental health problems. The prevalence of psychotic disorders has increased rapidly in the last decade – specifically, a tenfold increase between 2005 and 2016 has been reported *(6)*. More than 90% of people in prison suffer from substance-use problems during their lifetime, and about 75% have some form of personality disorder. Nearly half of all people in prison have chronic somatic illness, undiagnosed or neglected following diagnosis *(4)*.

Many people in prison have been injured in acts of violence or various kinds of accident, which are often due to substance abuse. There is a wide range of treatments available for patients with substance use disorders, including opioid substitution therapy (OST), detoxification with opioid agonists, detoxification without opioid agonists, and psychosocial treatment. Criminal Sanctions Agency is responsible for the non-medical treatment. OST is available for all sentenced prisoners and those in pretrial detention. In 2015, there were 411 people in prison receiving OST, representing 13.8% of the prison population recorded that year. For these individuals, urine or sputum screening for illicit drug use was mandatory *(4)*.

Nearly half of people in prison have antibodies for hepatitis C (HCV), in line with previously published studies *(7)*. All people in prison diagnosed with HCV are treated according to the national programme, and all undergo the same procedures *(8)*. HIV/TB coinfection is currently negligible in Finland, corresponding to less than 1% of the prison population *(7)*.

More detailed information about the prison health system in Finland and its statistics may be obtained in the relevant WHO country profile *(4)*. The system is considered to have equal standards for prison and community health care, providing equivalent care and thus adhering to international standards for prison health.

2.3 Delivery of care

2.3.1 Introduction

VTH has three major departments: the outpatient services department, including dental care, which consists of clinics located in every Finnish prison; the psychiatric hospital, which has departments located in Turku and Vantaa prisons; and the prison hospital for somatic care, which is located next to Hämeenlinna prison. In 2019 the Board made the decision to proceed in combining the hospital units. Located in the last of these is the pharmaceutical and logistical department, which is responsible for the supply of all medicines, medical devices and health-care materials to the prison hospitals and outpatient clinics. The dental department consists of 12 dental surgeries located in prison outpatient clinics. While most outpatient clinics are open on weekdays, the outpatient departments in the three largest prisons

– in Helsinki, Vantaa and Turku – are open daily. These clinics are nurse-led and physicians mainly have a consulting role. Patient consultations and sometimes even physicians' appointments are performed using telemedicine. Special health-care services are procured from third-party service providers, mainly public hospitals.

2.3.2 Availability

VTH provides health care services to all prison population. When a person is incarcerated, within 24 to 72 hours of their arrival in prison there is a thorough health evaluation conducted by a nurse. This evaluation consists of assessment of infectious and noncommunicable diseases (NCDs) and screening for mental health problems, harmful use of alcohol and drug use (4), and assessment of the prisoner's work and functional capacity. If the person assessed needs withdrawal medication, it is provided after consultation with a physician.

Screening for infectious diseases includes sexually transmitted infections, hepatitis B and C, and HIV (all three are offered routinely, using an opt-out system); following this, a medical appointment is scheduled when necessary. HIV testing is available whenever the need is recognised, and is offered binually. As a country, Finland has taken an active role in eliminating HCV, which also involves testing upon arrival in prison and following completion of treatment; care is provided to those who are prepared to commit to treatment. In 2019, there were 144 patients treated for HCV, accounting for 5% of the total prison population.

NCDs are also evaluated and treatment plans drawn up. Dental care screening is offered to everyone and standardised screening is conducted annually, every two or every thress years, depending on co-existing conditions. Dental care is is provided for all. Thorough plans for medical treatment and rehabilitation are drawn up and conducted in due course.

People in prison are able to access outpatient clinics upon request and according to their perception of need. For this purpose, people in prison contact the outpatient clinics using a special printed form and an answer is given within three days. Criminal Sanctions Agency is currently carrying out a project aiming at electronic ways of communication.

2.3.3 Range of services provided, including for specific health issues and specific groups

Some people in prison have linguistic problems for various reasons. Fellows living in prison or prison staff may assist illiterate or foreign individuals in contacting the health services. Foreigners in prison are assisted by using an interpreter and some printed materials are delivered in various languages. Most prisons are equipped to accommodate disabled people. Females in prison are given the option of being evaluated by a female nurse. There is also a specific service for people undergoing gender transition through which they are provided with the necessary medication.

2.3.4 Continuity of care

Further attention and development work are still needed for continuity of care. When an individual is released from prison, they receive a medical plan and a medical appointment is scheduled, especially for those on OST. The same principle is applied

to NCDs: a week's supply of prescription medications is given on release, as well as three-month prescriptions and a medical appointment is scheduled shortly thereafter. In preparation for the medical appointment, the individual is given on release printouts of all their medical data to bring to their community physician (for more on health information, see section 2.3.9). In spite of these measures, many people formerly living in prison neglect to take care of their health and miss scheduled medical appointments.

2.3.5 Quality of care

All care in Finland is provided according to national guidelines to ensure the quality of services provided. VTH follows these guidelines to ensure the quality of its services. These standards of health care are applicable both to the general population and to the prison population, adhering to the principle of equivalence. Valvira supervises and guides health-care professionals and ensures that the services provided in various medical facilities, both in the community and in prisons, are satisfactory *(9)*. Organizational supervision is provided by Valvira and AVI. Valvira supervises and guides health-care professionals and medical facilities in both the private and public sectors. AVI is the regional authority in charge of directing, licensing and overseeing health care. The aim of AVI is to ensure that high-quality health-care services are available for citizens.

2.3.6 Patients' rights

All people in prison are guaranteed dignified treatment in prison health care and their privacy is respected. Patients have the right to lodge an official complaint about the quality or availability of care, and in practice this is achieved by making a complaint through the office of the deputy ombudsman.

2.3.7 Financial aspects

Costs related to imprisonment are the responsibility of the Criminal Sanctions Agency. VTH has its own annual budget. A remarkable amount of the budget - nearly 1 M€, representing approximately 5% of the total annual budget, is spent to cover the Hepatitis C treatments conducted according to the National strategy. The costs of health care and medication for people in prison are fully funded by the national government, regardless of nationality or length of incarceration.

2.3.8 Health coverage in prison – costs

The VTH annual budget is tight. For the three-year period 2018–2020, the annual figures were €18 million, €19.1 million and €19.3 million, respectively. The budget covers costs related to care provided in VTH clinics, VTH hospital care, dental care, special health care and other services provided by third parties, medication, all staff salaries, administration, management, travel (doctors and nurses may cover a number of clinics), information and communication technology, and development initiatives.

2.3.9 Health information

All patient data are stored in an electronic patient data record system, which is used on an organizational basis. However, such data are stored but not transferred into the national archive (https://www.kanta.fi/en), mainly because of compatibility issues and

the need for software updates, which are due to be finalized by 2020, following which the transfer of health data from prison to the national archive may be initiated. This will also help in developing continuity of care. Until full implementation is possible, the current procedure involves printing medical data which are given to people on their release from prison (for further details, see section 2.3.4).

Even though the Finnish health information system may be relatively advanced in European terms, there is still information that is not captured on a regular basis, which makes it difficult to continually monitor the health status of people in prison. For example, the number of people treated for HCV is available for 2019 (144 patients treated out of 280 identified) and also for HIV (10 patients identified, all of whom are receiving treated), but not the number of fully immunized for hepatitis B (HBV). It should be noted that both antiretroviral therapy (ART) coverage and immunization coverage rate by vaccine for each vaccine in the national schedule are among the WHO 100 indicators to assess progress towards universal health coverage *(10)*.

2.4. Evidence on the impact of changing the governance model

Before responsibility for health in prisons was transferred from the Ministry of Justice to the Ministry of Health, there was no organization supervising or auditing care. Following the transfer, AVI and Valvira have together conducted audits of the quality of care in all polyclinics and hospitals serving people in prison. After the initial audits of all facilities had been finalized, a sampling strategy was implemented to ensure that between three and five facilities are audited annually. Self-auditing on regular basis following standardized procedures is conducted by VTH. Transparency is recognized as a key principle, so the audit results are possible to obtain upon request from the AVI (https://www.avi.fi/web/avi/aluehallintovirastot).

Although there are yet no publicly available data that may objectively quantify the clinical or humanistic gains obtained from the governance transition, the perception is that the quality of health care has greatly improved since 2016, mainly because the principle of equivalence has finally been properly implemented.

After the transfer it has proven to be easier to recruit permanent medical staff. There are plans to study the health and well-being of people in prison (Wattu IV) as well as the cost-effectiveness of health care provided to people in prison. Wattu IV will be incorporated in Finnish population studies. This will provide an opportunity to better compare health and wellbeing of people in prison with the rest of the population.

The established cooperation between VTH and Criminal Sanctions Agency is on-going with the trust that both parties respect each other's' area of expertise and decision making.

3. Portugal

3.1 General presentation of prison and health-care system

In Portugal, health-care provision for people in prison, including in youth detention centres, is a state responsibility. All youth and adults in detention have the right to receive health care, of a quality at least equivalent to that available to the general population. The prison health system, under the direction of the Directorate-General of Prison and Reintegration Services (DGRSP), interacts with the Portuguese National Health Service (P-NHS), a collaboration that makes it possible for P-NHS services to be used whenever DGRSP health services are insufficient. As such, there is a mixed system involving DGRSP, the main provider of health care in prison, and the P-NHS, which supplements the system and responds to unmet needs.

3.1.1 Main actors

In Portugal, the prison health system is the joint responsibility of DGRSP, under the Ministry of Justice (providing basic health care), and the Ministry of Health (providing supplementary care for certain conditions, as required). All health-care services and products that are provided to people living in prison establishments and to young people living in educational centres are coordinated by the Centre of Competencies for the Management of Health Care (CCGCS), which is part of DGRSP.

3.1.2 Coordination between the main actors

Prison establishments are functionally and organizationally dependent on DGRSP and provide all primary health care and some specialized care to all people in prison, including young people. All prison establishments have health services available, including family medicine (general practice) and nursing care. In some prison establishments, additional specialties such as psychiatry, psychology and dentistry are also available. Access to these additional specialties is always guaranteed by an internal referral system covering the entire prison system. Since 2009 all people in prison have been covered by the P-NHS by law *(11)*. All specialized care that cannot be delivered through the prison health service is therefore provided by the P-NHS on an equal basis to that provided to the general population.

3.1.3 Historical perspectives

Until the 1980s, almost all health care provided to the prison population was based on resources made available by the Ministry of Justice, resulting in a self-sufficiency model. During the second half of the 1980s, this self-sufficiency model was seriously hit both by a significant increase in the prison population, whose numbers doubled, and by the changing social and personal habits of the prison population, which was characterized by increased drug consumption and higher incidence of infectious diseases and mental illness. In response to the growing health-care needs, prison services adopted a twin strategy that involved:

- reinforcing the self-sufficiency model, through investment in human resources, infrastructure and equipment; and
- seeking a closer collaboration with Ministry of Health structures, which resulted in a pilot partnership model.

As an example of this cooperation, there was an agreement signed in May 1987 between the Psychiatric and Mental Health Unit of the Medical School of the Nova University of Lisbon and the Health Directorate of the Prison Services. This agreement served as the catalyst that led to the development of the Psychiatry Service for the Hospital Prison Unit São João de Deus in 1988 and the Psychiatric and Mental Health Clinic of Santa Cruz do Bispo in 1994.

During the second half of the 1990s, the prison population increased by 30% compared to 1985, which represented an almost threefold increase over 1980. This left the prison health system in an unbalanced state in which the available resources were insufficient to meet the health-care needs of a population marked by a high incidence of serious health problems, including drug use disorders, HIV infection, hepatitis infections, tuberculosis (TB) and mental health disorders.

Against this background, a resolution of the Directorate of Ministries was published in 1996 which approved the Action Programme for the Prison System, which set out a number of strategic options. There was a restructuring of the DGRSP, during which the Direction of Health Services (DSS) was created. This consisted of a technical commission whose aim was to reorganize DGSP health services. The DSS was later replaced by the CCGCS, reporting directly to the director-general.

In 2009, Law 115/2009 was published, which established the rights of the prison population *(11)*. These rights included:

- benefiting from the services of the P-NHS;
- having access to care within the P-NHS under conditions identical to those available to all citizens;
- receiving health care of the same quality as that guaranteed to the general population;
- having access to continued care at the points of transition (admission to and release from prison); and
- receiving sustained social and economic support, specifically in matters of social security, employment, professional training, education and health.

In order to establish a collaborative approach, a protocol was established between DGRSP and the Ministry of Health for early detection and treatment of TB in the prison population, with the aim of reducing within-prison transmission *(12)*. This initiative appeared to contribute to a significant reduction in TB cases inside prisons, but it coincided with a reduction in TB incidence in the general population: there was a clear trend towards active case finding before entry to the prison system, so what actually caused the change is debatable.

This synergy also led to the development of protocols between hospitals managed by P-NHS and prison establishments. These allowed people in prison to gain access to infectious disease and hepatology appointments and to receive treatment for HIV/AIDS and viral hepatitis under conditions equivalent to those enjoyed by the general population.

Currently, under the terms of this collaborative agreement, the feasibility of integrating health information from the prison system into the Shared Services of the Ministry of Health (SPMS) is being investigated. This would also include the possibility of further extending access to other medical specialties under the P-NHS, including telemedicine.

3.2 Characteristics of prisons and people in prison

The prison population in Portugal, in December 2018, consisted of 12 867 individuals, of whom 285 were considered unimputable. The most recently published official capacity for prisons in Portugal is 12 923 *(13)*, which gives an occupancy level of 99.6% – a lower value than that reported in 2016 in the WHO country profile, which recorded a figure of 114%, indicating overcrowding *(4)*. In the course of 2018, there were 5449 individual releases and 4876 admissions recorded, showing a significant turnover. According to the European Commission, Portugal is rated as a country where the average length of imprisonment is very high, which is defined as being more than 25% above the European median value *(14)*. In December 2018, 17% of people in prison were awaiting trial *(15)*, and among those convicted, the most frequent offences were crimes against property (32.6%), followed by crimes against people (27.5%) and drug offences (15.7%). The latter offences relate to the drug trade, as in Portugal there is a policy of decriminalizing drug consumption *(16)*. The remaining categories correspond to crimes against the state (10.3%), crimes against life in society (7.0%) and other crimes (6.9%). Most people in prison have sentences of less than nine years, and the most common sentence is between three and six years.

Females represent 6.4% of the total prison population (n=828). Most of the prison population is of Portuguese nationality (n=10 914; 84.8%), while foreign individuals represent about one seventh of the total (n=1953; 15.2%). The proportion of female foreigners (20.8%) is considerably higher than the proportion of male foreigners (14.8%). The average age of the prison population is 37.9 years. The majority of people in prison are in the 25–49 age range (72.0%); 14.6% are 50–59 years; 6.5% are 60+ years; while the juvenile population (under 21 years) represents 1.3% of the prison population.

Some 3% of people in prison are illiterate, and another 3% can read and write but have no formal education; the educational level of 2% is not specified. The great majority have some level of formal education (92%). Of these, nearly one third had completed the third cycle of basic education (nine years of formal schooling; 30.9%), and a small proportion completed university education (2.8%).

The pattern of infectious diseases in prison suggests a considerable burden of HCV, with 14.4% of the prison population testing positive *(4)*. The reported values for HIV vary considerably depending on source and year, ranging between 3.6% and 10% *(4, 17, 18)*. HBV seems to be rare, with the proportion of positive tests at around 2.4% *(18)*. There are no national data on the prevalence of all sexually transmitted diseases, as only syphilis data are analysed *(4)*. With respect to NCDs, a study conducted in a female prison in Portugal reported that the prevalence of anxiety was around 44%, insomnia 46%, depression 32%, hypertension 21%, diabetes 8% and cancers 4% *(18)*. Although these values cannot be extrapolated to the whole prison population (and they are likely to suffer from a degree of information bias), they clearly suggest a high frequency of mental health problems in this population.

More detailed information about the prison health system in Portugal and its statistics may be obtained in the relevant WHO country profile *(4).*

In Portugal there are 48 prison units, one prisoner hospital, two prison psychiatric clinics, three overflow wards and six educational centres for youth. The geographical distribution of prison units takes into consideration the proximity of people in prison to their families and homes in order to facilitate better social and family reintegration once sentences are over. Prison units are classified into four groups, according to the type of offence leading to imprisonment, their security level and the complexity of the management system: special security and high management complexity (n=1); high security and high management complexity (n=20); high security and medium management complexity (n=23); and medium security and medium management complexity (n=5). The six educational centres are set up for three types of youth regime: closed, semi-open and open.

3.3 Delivery of care

3.3.1 Introduction

The provision of health care to people in prison in Portugal is the responsibility of the DGRSP and is coordinated by the CCGCS, reporting directly to the director-general.

In all prison units, there are health services with at least one specialty of family and general medicine (general practice) and nursing. These health units provide primary care and evaluate the need for specialized care, referring people in prison to units where special care is provided, both within the prison system and within the P-NHS. All Portuguese and foreign people in prison are entitled to receive health care under the P-NHS.

Standardized provision of health care is ensured by the existence of the *Manual for health care provision in the prison system,* where all actions to be followed by health-care professionals are described in detail (while respecting the technical autonomy and clinical independence of these professionals).

3.3.2 Availability

Once people have been admitted to prison, a health assessment is undertaken by health-care professionals. A nursing appointment is made in the first 24 hours, followed by a medical evaluation in the first 72 hours. In this initial nurse-led assessment, a formulary is used where data are collected on vital signs (by observation and point-of-care evaluation of blood pressure, heart rate, glycaemia and oxygen saturation), relevant medical history, medication used, and a specific assessment of TB signs and symptoms. The Norton Scale is used to collect information on five major domains – physical condition, mental health status, activity, mobility and incontinence.

In most prisons there is no pharmacist in charge, so medication is dispensed by a pharmacist technician who oversees procurement and stock replenishment, which are agreed with a local community pharmacy selected annually by public tender. Medication is prepared by a nurse as a unit dose for each inmate and all medications are administered using directly observed therapy.

The law states that a medical examination must occur within the first 72 hours, but in some prisons in Portugal this happens on the following day. At this time, the individual is asked about any previous diagnostic examinations that may allow infectious diseases, NCDs and other conditions, including HIV/AIDS, viral hepatitis,

TB, diabetes and hypertension to be identified. If the person discloses that they have recently been admitted to hospital, direct contact is made to obtain access to examinations that have previously been carried out. Otherwise, a request is made for analysis, which is conducted by external providers within the P-NHS (from the National Health Institute Dr Ricardo Jorge (INSA)) who visit the prison; they are responsible for assessing the presence of antibodies and antigens for HIV, HCV and HBV. Tests are not mandatory but are routinely offered at admission using an opt-out system and are repeated annually. Whenever positive cases of HIV or HCV are identified, an appointment is scheduled in a hospital with which an agreement is in place, and if confirmed, cases are recorded by the hospital in the national system.

Following the initial TB assessment, an algorithm is applied which requests an X-ray examination whenever two or more characteristic signs or symptoms are detected. The X-ray is taken by mobile units, operating under the auspices of the Directorate-General of Health, which visit the prison 2–3 weeks later. Whenever TB cases are confirmed, responsibility for notification lies with the prison system. In all prisons, there is also screening for sexually transmitted infections and for oral health, at or soon after admission *(4)*. Illicit drug use, including alcohol consumption, is also evaluated at admission, by clinical observation by a nurse coupled with self-reporting. When a person is identified as experiencing withdrawal syndrome, a physician is immediately contacted to initiate appropriate treatment. Screening for oncological conditions is also undertaken at admission, according to sex and age group and following the legally approved guidance of the Directorate-General of Health for the general population *(19)*. This guidance indicates that population screening under the P-NHS is primarily targeted at asymptomatic individuals to make early-stage identification of breast cancer (women aged 50–69), uterine cancer (women aged 25–60), and colorectal cancer (both sexes, aged 50–74).

More than half the prisons have mental health support services. A wide range of treatments for substance use disorders is available, including OST, detoxification with and without opioid agonists, mutual support/self-help, and other psychosocial treatments *(4)*.

A full vaccination scheme for HBV is available to all eligible people in prison. Under the collaborative agreement established between DGRSP and the Ministry of Health, early detection and treatment of TB are available in prison. People in prison also have access to specialized treatment for infectious diseases, including HIV/AIDS and viral hepatitis, under conditions equivalent to those enjoyed by the general population. In 2015, 10 158 individuals were tested for new or relapse TB, 53 were tested for multidrug-resistant TB, and 37 completed TB treatment. In the case of HIV/AIDS, 516 of the 621 who tested positive for HIV received ART *(4)*.

3.3.3 Range of services provided, including for specific health issues and specific groups

During the initial assessment or prison stay, if any health problem requiring specific care is detected and if the services required to treat it are unavailable, people in need of care are referred to another prison unit where a specific response to the identified problem (such as psychiatry or medical dentistry) is available or to hospitals serving the P-NHS in the region.

In some prisons, there is a drug-free unit, which has limited capacity and is based on the principles of a therapeutic community (adapted from the Portage programme).

Admission to this unit is considered a privilege, so the first step is to demonstrate willingness, which is achieved through a petition made by the inmate or, in some cases, by physician referral. The first appointment is mainly used to evaluate the individual's knowledge of the way the unit functions and to assess their motivation to become drug-free. At this point, referral to a psychiatrist may be made so that detoxification treatments can be progressively titrated. The individual then has to wait for some time (usually 1–4 weeks) for a second appointment, at which their motivation is re-evaluated (through a standardized scale) and their duties within the unit are detailed; the system is also explained in which points are awarded for good behaviour and deducted for infringements – reaching zero points triggers exclusion from the unit. If the inmate's interest persists throughout this process, a collaboration with a psychologist is initiated to achieve total abstinence. Once this stage has been reached, a third appointment is booked, at which the presence of drugs in sputum or urine is evaluated, and if negative, the individual is allowed to enter the unit. (The only exclusion criterion – apart from drug consumption – is having a psychiatric diagnosis.)

There is a hierarchy within the unit that consists of three levels – new members, responsible members and old members; the top level is the mentor (normally only one, an inmate who is about to be released). Duties and rights vary according to this hierarchy, but all have in common the fact that they are never allowed to be alone. Members are accommodated in a specific setting within the prison, which has totally different conditions, including a cafeteria, a TV, some sofas, etc. Periodic and unannounced checks for drug consumption are carried out. The maximum time a person is allowed to stay in the drug-free unit is 36 months. The major flaws that have been identified in the unit are lack of social care support, absence of a setting in which the transition phase can be managed, and lack of flexibility over incarceration time to reflect meritorious behaviour.

3.3.4 Continuity of care

When people are admitted to prison, the health-care professionals contact community or hospital providers within the P-NHS to obtain the necessary health data (as of 2020, there was no access to electronic patient records within the P-NHS). This contact aims to identify health or therapy-related issues to ensure continuity of care (such as provision of OST) within the prison system. There is no medication reconciliation, as the general rule is to keep the same treatment as was used before incarceration.

When the individual is released from prison, they carry a clinical report to make available to their P-NHS physician and one week's supply of medication to prevent unintended interruptions of chronic treatment. In the case of OST, the inmate carries a discharge letter so that they can go directly to one of the P-NHS units available in the community and have immediate access to the medication required. These procedures are set out in the above-mentioned *Manual for health care provision in the prison system*. However, in practice, there are many situations in which an individual leaves prison to go on trial, and if they are acquitted, they may only return to prison to collect their belongings. In such situations, there is no possibility to repeat any clinical evaluation or examination, and the only feasible option is to print out a medical record, including a therapeutic plan, which the person may take with them to their community health-care provider. In these circumstances, the person is also given one week's supply of medication, except in the case of methadone, which is agreed directly with the centre for integrated responses in the area of residence.

3.3.5 Quality of care

All youth and adults deprived of their liberty have access to health care of at least equivalent quality to that available to the overall population *(20)*. The care provided follows the guidelines and norms issued by the Directorate-General of Health. The dental care of people in prison is provided free of charge by DGRSP and there is no form of co-payment in place. The same applies to medication, which is provided free of charge to people in prison; the associated costs are partly covered by the P-NHS (reimbursed in the same way as they are to the general population) and the remainder is funded by the prison budget *(21, 22)*.

3.3.6 Patients' rights

People in prison have rights equivalent to those enjoyed by the general population. The Portuguese state abides by international regulations on the rights of patients.

3.3.7 Financial aspects

The prison health system is entirely funded by the DGRSP budget. The system in place ensures that all health care is provided entirely free of charge to all people living in prison, with no room for any type of co-payment, even for services and products for which such arrangements exist for the general population. As such, all pharmaceutical treatment is distributed free of charge to people in prison and made available through directly observed treatment, supervised by nurses working at the prison units.

All prison health-care professionals are contracted by and work under the auspices of DGRSP. They are bound by the same terms and conditions as professionals working for the P-NHS, follow the same career path development, including in terms of education, training and requirements for continuous professional development, and are regulated by the same professional societies. Health-care professionals working for the prison service and for the P-NHS enjoy a similar level of clinical independence.

3.3.8 Health coverage in prison – costs

All prisons and youth detention centres have clinical services in which nursing and family medicine services are available. In addition, there are some prisons where specialized care is available through an established referral network; this includes psychiatry, psychology, dental medicine and infectiology. Whenever this referral network is not available, people in prison may resort to the P-NHS structures within the area of influence of the prison establishment. Regardless of the arrangements in place, all these services are provided free of charge to all people in prison.

3.3.9 Health information

In all prisons, paper-based medical records are used. These combine the nurse formularies, medical notes, any examinations undergone by the inmate, medication taken, and any urgent care visits. In some prisons, the most relevant data are then stored in an aggregated format using Excel or similar software. Notification of some diseases diagnosed and treated outside prison for which there is a national registry (namely, cancer, HIV and HCV) is carried out at the external hospital. Only TB is registered by the prison responsible physician, who has responsibility to notify the competent bodies. There is a project anticipated to align and integrate the prison health system with the national one, which is currently fully automated. This has not yet been pursued, mainly because of limited funding.

3.4 Evidence on the impact of changing the governance model

It is important to note that, unlike the other countries described in this brief, Portugal has not undergone a formal transition to the Ministry of Health and prison health is still the responsibility of the Ministry of Justice. However, as explained in the introductory section (3.3.1), collaborative agreements have been made to improve the health status of people living in prison and the performance of the health system that serves them. In this section, some data are provided to demonstrate this.

At the beginning of 2017, a collaboration protocol between the P-NHS and the prison system was established, through which a specific workflow was implemented (**Fig. 1**) *(23)*.

Through the established protocol, people in prison started to benefit from:

- periodic visits of P-NHS specialized medical staff; and
- necessary examinations performed during these visits.

All individuals completing treatment were cured, which resulted in financial savings.

The establishment of this protocol prevented at least 10 visits per person to the hospital (the average number of appointments needed for this condition). For each visit, the associated costs included the fuel for the van transporting the people in prison, the associated amortization costs of the vehicle, and the staff required to accompany them (on average three people, including a driver and two officers, each of them spending on average three hours per visit, costed at an average monthly salary of €900). Considering that, for the year in question, there were 68 individuals being treated for HCV, the costs associated with 680 hospital visits were saved.

When the protocol was initiated, there were 215 individuals living in prison who had been diagnosed with HCV, representing 18% of the prison population at the time. The majority of these (79%) were infected with HCV alone, while 21% were simultaneously infected with HIV. Among those with HCV only, 50% had a positive viral load and were therefore eligible for treatment. Some of these were released or transferred, but 80% completed treatment, resulting in a total of 68 individuals being cured of hepatitis C.

By arranging medical appointments at prison units, an enormous contribution was made to the well-being and human dignity of people in prison, as they no longer had to wait hours in a hospital, handcuffed and escorted by a prison officer.

This protocol is a good example of a successful partnership bringing obvious benefits both to the recipients of treatment and – considering the potential savings – to the health-care system as well. In fact, this success led to the protocol being extended to another prison unit in the same region (Santa Cruz do Bispo, a female prison) *(24)*. Subsequently, with the implementation of dispatches 6542/2017 and 283/2018, the protocol was extended to all Portuguese prisons *(25, 26)*. Treatment of other medical conditions may also benefit in future from establishing similar partnerships.

Fig. 1. Flowchart describing the patient pathway for HCV treatment, according to the protocol established between DGRSP and the P-NHS

4. England

4.1 General presentation of prison and health-care system

The United Kingdom has a long history of developing good practice standards, advancing data and intelligence systems, and supporting new research in prison health. It is one of the few countries in the world that, in 2006, transferred responsibility for prison health care from the Ministry of Justice to the Department of Health (renamed the Department of Health and Social Care (DHSC) in January 2018).

Ten years later, in 2016, Public Health England (PHE) published its *Rapid review of evidence of the impact on health outcomes of NHS-commissioned health services for people in secure and detained settings to inform future health interventions and prioritisation in England (27)*. The importance of prison health as public health and the principle of equivalence of health care in relation to community health systems are central to the organization of prison health in the United Kingdom. Management and coordination of all relevant agencies and resources contributing to the health and well-being of people in prison are a whole-of-government responsibility, and this case study gives tangible examples of how this has been achieved in the United Kingdom.

Work on developing a prison health system which is comparable to that available to the outside community in both standards and outcomes is an iterative quality development process. Developments in the devolved administrations of the United Kingdom have occurred in line with local policy improvement. Wales transferred responsibility for prison health care to the Local Health Boards in 2006, at the same time as England; Scotland made the transfer in 2011; and Northern Ireland completed the transfer in 2012.

This case study focuses on the experience of England, as it has the largest prison estate within the United Kingdom and a complex health system.

4.1.1 Main actors

Prison health services in England are funded by DHSC, a department of the United Kingdom government. Health services are commissioned by National Health Service (NHS) England/NHS Improvement from health-care providers such as NHS community health-care providers (such as hospital trusts) and private health-care provider companies. Primary care services and some specialist health services are provided in prisons; people in prison visit local hospitals in the community for secondary care appointments or emergency/tertiary care.

4.1.2 Coordination between the main actors

Acknowledgment that health services in prison are delivered in a justice setting and require close alignment of approaches and resources led to the development of the National Partnership Agreement for Prison Healthcare in England *(28)*.

An agreement involving Her Majesty's Prison and Probation Service (HMPPS), PHE and NHS England had been in place since 2013 (formally signed off in 2015), following the introduction of the Health and Social Care Act (2012), with the aim of supporting the commissioning and delivery of health care in English prisons. In 2018, the original tripartite partnership was joined by the Ministry of Justice and DHSC (**Fig. 2**). This marked the beginning of an even stronger level of cooperation and cohesiveness between all the bodies that have an impact on the policy, commissioning and delivery of health and social care services in both public- and private-sector prisons in England.

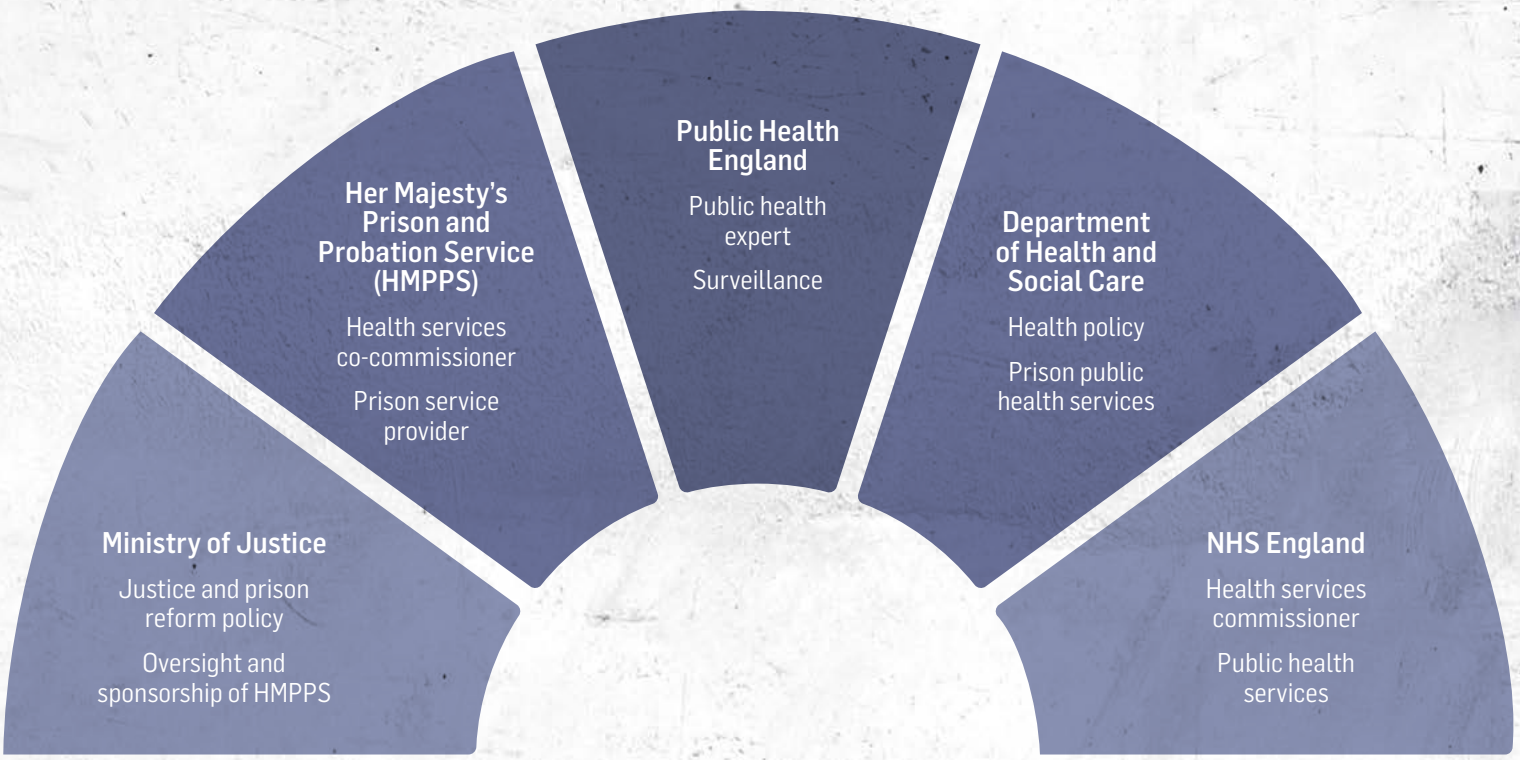


Fig. 2. Members of the National Partnership Agreement for Prison Healthcare in England (2018)

Source: National Partnership Agreement for Prison Healthcare in England *(28)*

The National Partnership Agreement sets out:

- the defined roles of the five partners;
- their commitment to working together and sharing accountability for delivery through linked governance structures;
- their core objectives and priorities, and the workplans that provide the details of the activities to deliver their priorities; and
- the processes for partners to work together to improve data and evidence to better understand the health needs of people in custody and the quality of health and social care services delivered to people in prisons.

The three core objectives of the partnership agreement are:

1. to improve the health and well-being of people in prison and reduce health inequalities;
2. to reduce reoffending and support rehabilitation by addressing health-related drivers of offending behaviour; and
3. to support access to and continuity of care through the prison estate, pre-custody and post-custody into the community.

The National Prison Healthcare Board has responsibility for oversight and ongoing management of the agreement and delivery of its shared objectives. It oversees partnership risks and their mitigation, and enables dispute resolution. Each of the five members of the partnership share equal responsibility for the function of the National Prison Healthcare Board. The Board meets four times a year and the priorities for the agreement are reviewed regularly; the current agreement workplan runs from 2018 to 2021.

Governance at establishment level is provided through the development and operation of local delivery boards, which are led by the prison governor/director for private prisons and include providers of custody, health care, substance misuse and local authority leads for social care services. The work of the local delivery boards should be underpinned by a local delivery agreement to set out how partnership work is taken forward at a local level to support delivery.

Organizational governance structures exist in each individual organization, which are used to ensure decisions that have an impact on organizational spending and delivery are signed off appropriately. Each member is responsible for ensuring decisions are signed off and information is disseminated through the proper channels.

4.1.3 Historical perspectives

The historical events that have shaped and influenced decision-making on prison health in the United Kingdom demonstrate the interplay between a human rights perspective on prison health care, political will and the formation of central, national bodies to support the development of prison health care (**Fig. 3**). A key document in this evolution is NHS England's *Strategic direction for health services in the justice system: 2016–2020*, which outlined the strategic priorities that were essential for equitable development of health-care provision in all settings of the criminal justice system *(29)*.

1948
The NHS is established, providing free health care at the point of need for all. A decision is made that prison health should be excluded from the NHS.

The prison health system therefore develops independently of the community health system, with different staffing and services available to people in prison compared to the community.

1990
The longest (25 days) and most disruptive riot breaks out in Manchester's Strangeways prison. Two men die and 194 are injured.

A public inquiry, proving to be the most searching examination of penal policy, leads to sweeping changes in the penal system.

1996
Sir David Ramsbotham, Her Majesty's Chief Inspector of Prisons, writes a seminal report *Patient or prisoner?*, which considers health-care arrangements in prisons in England and Wales with a view to ensuring that people in prison receive the same range and quality of health services as those available under the NHS.

Ramsbotham concludes that the Department of Health/NHS should take over responsibility for prison health care from the Ministry of Justice, leading to the publication of *The future organization of prison healthcare* in 1999.

2006
Over a 10-year period, work in England and Wales proceeds to transfer responsibility of health care from the Ministry of Justice to the Department of Health; the transfer is finalized in 2006.

Local health-care organizations (primary care trusts) become responsible for commissioning health care, including health care in prisons.

2013
Following the Health and Social Care Act of 2012, new health-care structures are put in place, with NHS England taking responsibility for commissioning health care for people in prisons.

This results in a nationally agreed prison health-care specification, with local variations dependent on the needs of the population; it is supported by PHE's Health and Justice health needs assessment toolkit and the development of health and justice performance indicators to measure delivery and trends in prison health care.

2015
National Partnership Agreement signed between Her Majesty's Prison and Probation Service, NHS England and PHE to ensure a whole-prisons approach.

The Partnership Agreement is renewed in 2018, adding the Ministry of Justice and DHSC as co-signatories.

2016
A rapid review of the impact of these changes is conducted by PHE.

NHS England's *Strategic direction for health services in the justice system: 2016–2020* outlines the strategic priorities essential for equitable development of health-care provision in all settings of the criminal justice system.

Prison health care is considered to have improved in general, with increased access to effective health and social care, improved continuity of care for people as they transition between prison and the community, and a number of improvements in health-care delivery.

2018–2020
An inquiry into prison health care is conducted by the Health and Social Care Committee; it highlights the current challenges of organizing and delivering health care in prisons in England.

Refreshment of the National Partnership Agreement is under way to meet the needs from 2021 onwards.

Fig. 3. A brief history of health care in prisons in England since 1948

4.2 Characteristics of prisons and people in prison

There are 110 prisons in England currently but this is increasing. The prison estate is governed by HMPPS, which also oversees the five prisons in Wales. There are also 15 prisons in Scotland and three in Northern Ireland, although these are not run by HMPPS.

Responsibility for prisons is a devolved function, so United Kingdom prison statistics are published separately for England and Wales (Ministry of Justice), Scotland (Scottish government), and Northern Ireland (Department of Justice).

Prison population data are available weekly for England, Wales and Scotland, and quarterly for Northern Ireland. A report published in July 2020 on United Kingdom prison population statistics includes a range of information; it gives a total prison population of approximately 87 900, comprising of 79 453 in England and Wales, 7004 in Scotland and 1484 in Northern Ireland *(30)*.

In May 2019, 62% of prisons in England and Wales were overcrowded. Prison sentences were longer in 2020 than in 2010. The most frequent length of sentence served at the end of March 2020 was a determinate sentence of over four years, with around 48% of the sentenced population serving this length of sentence. The population in contact with the criminal justice system is far larger than the prison population itself. All people serving a custodial sentence come from communities, and almost all will return to their community, or another community, at the end of their sentence. At any one time, the proportion of offenders supervised by probation services outnumbers those serving a custodial sentence by around three to one.

Many other statistics on the prison population are available for England and Wales, published in the Ministry of Justice's *Offender management statistics quarterly*. One of the key findings in the report is that the prison population is ageing. In 2002, 16% were under the age of 21 compared with 6% in 2019, while the number over the age of 50 went from 7% in 2002 to 16% in 2019. In 2018, 5% of the prison population was female. Foreign nationals made up 11% of the prison population. People of minority ethnicities made up 27% of the prison population compared with 13% of the general population.

Many people in contact with the criminal justice system have multiple and complex needs. Compared to the broader population, people in prison experience a range of social, physical and mental health problems, impairments and barriers to equitable participation in society. The prevalence of needs among offenders in the community may be similar in character but not necessarily in extent. As there is limited comprehensive information about the health needs of offenders in the community, the prison population has been used as a proxy. In comparison to the general public, these health and social needs can include:

- higher prevalence of infectious diseases, and poorer vaccine coverage;
- higher prevalence of long-term conditions;
- higher prevalence and rates of substance misuse, including tobacco consumption;
- higher prevalence of mental ill health;
- higher levels of learning disabilities and lower educational attainment;
- a disproportionate number who had been in care as children;
- higher rates of pre-sentence homelessness, insecure housing and worklessness; and
- higher rates of violence and abuse experienced.

Each of these needs requires a response both while the person is in prison and upon release.

Further information on the health characteristics of people in prison in England is available in PHE's *Health and justice annual review 2018–2019 (31)*, the WHO country profile of prison health care in the United Kingdom *(4)*, and the WHO Health in Prisons European Database *(32)*.

4.3 Delivery of care

4.3.1 Introduction

Understanding the needs of people in prison is essential in providing appropriate care. A health and social care needs assessment approach has been taken in England to identify needs and services currently being delivered, while a gap analysis has been conducted to determine the level of equivalence between the health provision available to people in prison and that available to the outside community.

This approach includes speaking directly to people in prison about their needs and to staff members, as well as analysing health records and service utilization and delivery.

PHE's Health and Justice health needs assessment toolkit is used by health-care commissioners to inform the delivery of services in prison *(33)*. PHE has also designed a needs assessment toolkit specifically for older people in prison *(34)*.

4.3.2 Availability

NHS England Health and Justice is responsible for commissioning health care for children, young people, and adults across secure and detained settings, which include prisons, secure facilities for children and young people, police and court liaison and diversion services, and immigration removal centres. It is responsible for commissioning £503 million of services to meet a wide range of health and care needs across detained and secure settings, as well as sexual abuse/assault services.

Health and Justice services are commissioned via 7 Health and Justice teams across seven regions (North West, North East, Midlands, East of England, South, South West and London). NHS England Health and Justice commissioning supports effective links with clinical commissioning groups and local authorities to support the delivery of social care within secure settings and the continuity of care as individuals move in and out of them.

Health-care services are commissioned according to prescribed specifications *(35, 36)*, following evidence-based standards published by the National Institute for Health and Care Excellence (NICE) on the physical health of people in prison, which outline guidance on assessing, diagnosing and managing physical health problems of people in prison *(37)*. The NICE standards aim to improve health and well-being in the prison population by promoting more coordinated care and more effective approaches to prescribing, dispensing and supervising medicines.

A health assessment is made by a nurse on arrival in prison, with a follow up assessment within a week of arrival or within 24 hours, if required. The individual's health is assessed and any appropriate medications are prescribed and provided. The assessment includes diagnosis, management and treatment of infectious diseases (HIV, hepatitis, TB, etc.) as well as chronic diseases (diabetes, asthma, etc.). If further clinical investigations are required, these are arranged, including an appointment with a physician or referral to secondary care services. Infectious diseases are screened, and a physician's appointment is reserved, when necessary. Dental care, podiatry, optometry services, as well as mental health care are provided for all of those who need them. Need for prescribed medication is assessed by the health-care team and made available through the prison pharmacist. Where possible, and as close to arrival in prison as possible, the patient's previous primary care physician is contacted by the health-care team to obtain summary medical records and a list of prescribed medication.

The prison health-care workforce is organized by the providers of health care. All commissioned services specify that staff should meet the standards that apply to staff in the community providing the same services. There are several professional bodies that provide guidance and standards for the health-care workforce in prisons, including the Royal College of Nursing, the Royal College of General Practitioners and the Royal College of Psychiatrists. There are no defined numbers for the workforce, as the rationale is to commission services based on health outcomes, which implies that health-care providers should decide on the nature of the workforce on the basis of identified health needs.

4.3.3 Range of services provided, including for specific health issues and specific groups

Mental health services are guided by the NICE guidance on mental health, which covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system *(38)*. It aims to improve mental health and well-being in this population by establishing principles for assessment and management and promoting more coordinated care planning and service organization across the criminal justice system.

Social care is commissioned and provided by the local government office (local council) as it is in the community. Assessments for social care support require services to visit prisons. Referrals are made for support for these individuals in prison, such as special equipment paid for by the local government office, or physical adaptations to the prison environment which are paid for by the prison.

At the reception assessment or at a later time during a period of incarceration, issues related to accessibility of services (such as language or learning disability) may be identified, or specific services may be required to meet the health needs of an individual, such as lesbian, gay, bisexual, transgender and queer (LGBTQ) issues or particular religious requirements. If such issues arise, they are addressed through specific support – for example, by commissioning a translation service, obtaining easy-read materials, or accessing support through charity-sector organizations.

4.3.4 Continuity of care

People sent to prison may not be placed near their home and this can pose a challenge in facilitating continuity of care at time of arrival and release. All NHS patients have a unique medical number (NHS number) which can be used to access their medical records on arrival at prison, supporting the assessment of health needs on reception. A programme of work is under way to ensure that medical records made in prison can be linked with a person's general medical records in the community to support ongoing care on release.

Every attempt is made to ensure that all people leaving prison are registered with a primary care doctor in the locality in which they are resettling. Where possible, a summary of a patient's medical records is sent to the receiving primary care provider (general practitioner (GP)/family doctor) on release from prison. Alternatively, the released person is given a paper copy of their medical records during their time in prison to give to their new GP/family doctor. Where prescription medication is required, a person released from prison is given a small supply or prescription depending on the medication.

Health-care services in prison work closely with those in the community to ensure continuity of care is supported as effectively as possible. NHS England/Improvement's national long-term plan includes health and justice services to address health inequalities; one part of this plan focuses on increased investment to provide a service that supports people to access services in the community upon release (the RECONNECT programme *(39)*). It is recognized that preventing a decline in health on release through robust reconnection with health services in the community will contribute to reducing health inequalities in this vulnerable patient group and encourage them to take personal responsibility for their own health-care needs.

One of the challenges that can impede access to health care on release from prison is having no fixed abode, which can disrupt contact and communication as well as processing of various government welfare schemes.

4.3.5 Quality of care

Alongside health needs assessments of prisons that are conducted prior to commissioning services for them, NHS England/Improvement collect data from health-care providers on a range of indicators that gauge the quality of health service delivery; these include both process and outcome indicators and are called the Health and Justice Indicators of Performance. Since 2014, aggregated data providing assurance of the delivery and quality of NHS England/Improvement-commissioned health care across the secure estate have been extracted each quarter by providers at site level and processed centrally to provide regional and national reports.

4.3.6 Patients' rights

People in prison are treated as NHS patients in the same way as anyone in the general community. The principle of equivalence is enshrined in the commissioning of health-care services. The Royal College of General Practitioners has published a

position statement clarifying how equivalence of care should be defined in secure settings; it states that people in prison should be "afforded provision of or access to appropriate services or treatment [which are] at least consistent in range and quality with that available to the wider community" *(40)*. This implies that people in prison have the same rights as all patients to access services and to raise complaints about services. This is supported by the prison service and the health-care services by having a complaints procedure that is explained to all people in prison. There are specific guidelines on how health-care services must respond to these complaints in a timely manner. All health-care services in prisons are monitored for quality by the same independent reviewers that monitor services in the general community.

4.3.7 Financial aspects

NHS England/Improvement's annual budget for health and justice services is currently approximately £500 million. Each jurisdiction in the United Kingdom publishes data on the cost per prisoner or prison place *(30)*. In 2017/18, the average cost per prison place was £39 385 in England and Wales, £35 601 in Scotland, and £54 893 in Northern Ireland.

4.3.8 Health coverage in prison – costs

All health care in prisons is free at the point of need, as it is in the community. People in prison do not pay for prescription medication (nor associated fees). Medication and other health-related products (such as condoms) are dispensed by health-care services.

4.3.9 Health information

There is an information-sharing protocol that establishes the principles that must be adhered to in order to have access to information, while preserving a person's rights and abiding by the General Data Protection Regulation *(41)*. A programme of work is currently under way to develop a Health and Justice Information System. This will allow data from prison services on health-related fields to be extracted from multiple sites in a consistent, automated fashion; relevant information such as appointments and risk information to be shared across systems; and medical records to be linked to those in the community to facilitate continuity of care on arrival and release from prison. A cross-government, cross-organizational governance group that supports prison reforms includes a workstream on data and intelligence.

4.4. Evidence of impact

The transfer of responsibility for prison health care from the Ministry of Justice to the Department of Health was initiated by the report *The future organization of prison health care* (1999) *(42)*, which scoped the situation and issues that were current at the time, in response to the findings of a highly critical report by Her Majesty's Inspectorate of Prisons in 1996 *(43)*. A paper on these prison health reforms, published in the *American Journal of Public Health* in 2006 *(44)*, reflected on the benefits for prison health of transferring responsibility to the Department of Health and the NHS, measured against the state of prison health care outlined in the

Inspectorate of Prisons report. Among the benefits cited by the paper are greater transparency, evidence-based assessment of health needs, tackling professional isolation, improving the quality of care, and integration of prison populations into wider public health programmes.

Ten years later, in 2016, PHE conducted a *Rapid review of evidence of the impact on health outcomes of NHS-commissioned health services for people in secure and detained settings to inform future health interventions and prioritisation in England (27)*. This evidence review found that, since the transfer of responsibilities to the Department of Health, there had been a significant improvement in the commissioning and provision of health care, leading to better health outcomes for people in prison. There are limited robust data to quantify this, but the findings from qualitative research have demonstrated that there is a wide range of strengths identified in the areas of strategy and leadership, data and intelligence, frontline services, and engagement with people in prison to inform service design and delivery.

One of the key issues that has emerged internationally, since the publication of WHO's policy brief on good governance for prison health in 2013 *(1)*, has been the task of measuring the impact of changes to prison health-care governance resulting from the transfer of responsibilities from justice ministry to health ministry. As one of the pioneers in developing the recommendations set out in the 2013 policy brief, England did not conduct a detailed exercise in measuring the baseline health outcomes for people in prison before and after the transition. Drawing any firm conclusions from a comparison of health outcomes before and after transition is confounded by the presence of other variables, such as changes and improvements in indicator development and data systems. Undoubtedly, this would have been an insightful addition in the preparatory phase of the transition.

One of the challenges in the organization of prison health care in England is that, despite a national specification of prison health-care services that are commissioned on an outcome basis, social care is funded and provided by local government offices in the area where the prison is situated. Continuity of care can also be challenging because health-care provision in the community is fragmented – for example, mental health and secondary care are commissioned through small local organizations (clinical commissioning groups), while substance misuse services and sexual health services are commissioned through local government offices. Although this allows commissioning that is appropriate for a local community, it relies on partnership capable of working across systems.

An example of good practice that is believed to strengthen positive health-care design and delivery in prisons is the focus on a national partnership approach that uses public health principles of designing health-care services based on needs assessments and measuring outcomes and processes through data systems and surveillance. Transparency is an important principle to uphold in the development and delivery of prison health care. In England, there are many statutory organizations that scrutinize prison health care (**Fig. 4**), and their reports and publications are considered at National Prison Healthcare Board level.

National Audit Office and Treasury

The National Audit Office (NAO) scrutinizes public spending for Parliament and is independent of government. The NAO and treasury scrutinize and hold National Partnership members to account for spending on prison health care, publishing public reports on their findings.

Independent Monitoring Boards (IMBs)

Every prison has an IBM. Voluntary members are appointed by the Ministry of Justice to monitor day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.

HM Inspector of Prisons (HMIP)

HMIP, an independent inspectorate, reports on conditions and treatment of those in prisons, young offender institutions and immigration removal centres.

Care Quality Commission (CQC)

An independent regulator of all health and social care services in England. CQC ensures that services meet national standards of safety and care. It inspects prison health care and social care services.

Ombudsman

The Prison and Probation Ombudsman (PPO) is appointed by the Secretary of State for Justice and investigates complaints from people in prison and those subject to probation supervision. The PPO is also responsible for investigating deaths in prison custody and producing fatal incident reports.

Local Authorities

Local authorities are responsible for adult social care in prisons and can require relevant NHS bodies and health service providers to respond to queries to enable the authority to discharge its scrutiny functions. Local authorities do not have powers to demand access to prisons.

Healthwatch

An independent consumer champion for health and social care across England, working to ensure consumer views are represented locally and nationally.

Internal Organizational Governance

Partner organizations have in place internal (local/regional/national) governance which oversees each partner's specific areas of responsibility.

Coroners

Coroners investigate deaths that occur in custody or otherwise in state detention and have a duty to make a report to prevent other deaths. "Regulation 28" reports are shared with relevant organizations to prevent future deaths.

Fig. 4. The range of statutory organizations that scrutinize prison health care in England

Source: National Partnership Agreement for Prison Healthcare in England *(28)*

5. Discussion

This report described three distinct governance models for prison health, showing that there is no unique solution that will fit every country. However, it also showed similarities in the countries portrayed that seem to be crucial for successful improvement of health in prisons.

One similarity is the establishment of partnerships, across sectors and within sectors. Agreements established between the justice and health sectors may vary in format, but their essential task is the same: to find solutions that not only answer medical needs effectively while respecting security procedures, but also – crucially – maintain standards of respect for human dignity and protect the rights of people deprived of their liberty.

It has been highlighted that using workforce standards and staff from national health services may be a possible solution that ensures equivalence of care. Other models in which prison health-care staff work exclusively in prisons are also possible, but the essential point is that the workforce should be subject to exactly the same requirements, in terms of qualifications, continuous professional education and career progression, as their peers in the community.

In addition, the need was recognized for specific courses tailored to provide health-care staff with the skills to work in prison settings. Different models exist to put such arrangements in place. In Finland, for instance, working in prisons is a compulsory rotation within the career development residency, giving clinicians an opportunity early on to recognize their motivation and aptitude for work in prisons. In Portugal, this stage is not compulsory, but it is also available and provided on site for all those following this career path. Other issues that affect workforce and practice have been debated – namely, the advantages and disadvantages of prison staff working exclusively in prisons and becoming full-time; and the possibility of developing a specific competency to equip staff with the skills needed to work in prison health, which would need to be recognized by professional societies and embedded in existing career paths.

The need to guarantee the clinical independence of staff was emphasized. This was an area also highlighted as potentially being most affected by the transfer of governing ministry. In countries where transition had been made from justice to health sectors, there was a perception among health-care staff that the transition had enabled them to give as much consideration to the interests of people in prison living with a disease as to the requirements of justice and prison security. The transition was accompanied by a transfer of staff contracts from the Ministry of Justice to the Ministry of Health. Oversight of practices remained, but it was conducted in a different environment and culture in which it was no longer permitted for physicians to be instructed to verify if an inmate's health was sufficient to warrant safe punishment.

There were different levels of technology implementation within the prison settings of the three countries observed. Paper-based systems continue to be used in some cases, while electronic prescriptions and medical records are in use elsewhere.

Nonetheless, even in these apparently more advanced cases, there is still no full integration (and in some cases, not even partial integration) with the national health information system. This has various implications in practice:

- Efforts to ensure continuity of care can be severely hampered if medical records cannot reach health-care services in the community. Also, when individuals are admitted, previously existing medical data are not automatically transferred, risking unnecessary repetition of examinations in the case of those living with chronic morbidities or previously identified infectious diseases. Evidently, there is still much work to be done to improve continuity of care between prison and community.
- To conduct timely evaluation of the health status of people in prison is a major challenge that requires additional policy options and allocation of resources. In general, in the countries studied, there are systems in place for initial assessment and monitoring of infectious diseases, although there are clearly flaws at the time of release, which are mainly attributable to lack of planning and of integration within the wider system. Indicators that were comparable across prisons and community and could be assessed in a timely manner would allow clearer measurement of health inequalities between these settings and would inform service design and delivery. NCDs and their risk factors are generally poorly assessed after the initial interview, except for occasional ad-hoc assessments for specific purposes. This is a matter of concern, as a natural upward shift in the occurrence of NCDs in ageing populations has been observed globally.

6. Recommendations

Based on the analysis made of the three different governance models, the main recommendations are as follows.

- There is no unique ideal governance model for prison health. Distinct collaborative agreements and intersectoral cooperation may provide an efficient solution to the management and integration of prison health into the national health system.
- Regardless of the governance model chosen, the key principles to be ensured are equivalence of care, clinical independence, respect for human rights and continuity of care.
- Should any Member State consider a change in their governance model, it is considered essential – in order to draw robust conclusions on the impact of the change – to conduct a baseline assessment of the existing infrastructures, processes in place and outcomes both for people living in prison (mostly clinical and humanistic) and for health-care professionals and the health-care system (mostly humanistic and economic).
- Creating a functional, reactive and integrated health information system is essential to monitor processes and outcomes of programmes of work considered and to evaluate if universal health coverage is inclusive of prisons. Such systems, ideally computerized, should be designed to facilitate continuity of care and maximize safety in bidirectional care transitions, while respecting the confidentiality of individuals.
- Whenever consideration is given to a transition in governance model, careful planning is recommended, and this should include, among other things, staffing issues (including qualifications needed and regulatory bodies responsible for defining and assessing competencies) and remunerations attributed (including bodies responsible for payment and defining banding levels).

Fig. 5, adapted from a model developed by PHE, summarizes a possible framework within which to consider the various aspects contributing to a successful transition. The first block ("Policy option") concerns assessing and exploring the existing political will and eventual drivers for transition. The second block ("Partnerships") refers to the evaluation of existing conditions that make it possible to develop agreements between the health and justice sectors and includes establishing shared priorities and approaches to support the development of a robust health-care system in prisons. The third block ("Preparation") refers to the previous assessment of the system – its resources, relationships, population issues and sentencing approaches – and calls for careful evaluation of how these issues may be modified according to the involvement of different sectors. The fourth and fifth blocks address the capacity to measure the impact of the transition: the fourth block ("Performance") calls for an assessment made before the transition; the fifth block ("Periodic review") calls for various assessments made in the period following the transition. Such assessments should be able to capture unmet health needs, the health status of the population considered, services available in detention settings, and – ideally – clinical, humanistic and economic indicators that are sensitive to change.

Fig. 5. Framework for consideration of factors leading to successful transition

7. Conclusion

It is extremely important to continue strengthening prison health systems through consideration of leadership and governance to ensure positive health outcomes for this vulnerable population. To achieve this ambitious aim, it is necessary for Member States to work collaboratively to understand the challenges involved and to jointly develop work that may contribute to potential solutions that benefit all actors involved, including policy-makers, prison administrators, health-care staff, people living in prison and the wider community. There seems to be a generalized need for improved data-collection methods, including information systems, to support the development of evidence-based approaches.



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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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