ROUTLEDGE

# PRISON HEALTH AND WELLBEING

EDITED BY JAMES WOODALL, MATTHEW MAYCOCK AND ROSIE MEEK

# PRISON HEALTH AND WELLBEING

*Prison Health and Wellbeing* blends theory with lived experience to explore the complex challenges and interventions that shape health and wellbeing for those living in, working in, and visiting prisons.

People in prison are far from a homogenous group, yet epidemiological evidence consistently shows higher rates of ill-health compared to the wider population. Historically, research has focused almost exclusively on individuals in custody, often overlooking the health needs of prison staff and others within these environments. This book addresses these gaps by offering comprehensive insights into the social, structural and cultural factors that influence health in prison contexts. Moving beyond a narrow focus on disease, disability and deficit, it adopts a salutogenic perspective – asking what keeps people healthy, not just what makes them ill. By reframing prison health through a holistic lens, this book provides a critical foundation for improving wellbeing in one of society's most challenging environments.

*Prison Health and Wellbeing* is an essential resource for students and scholars of criminology, public health and health promotion. It will also prove invaluable for policymakers, commissioners and practitioners delivering health services in prisons.

**James Woodall** is a Professor in Health Promotion at Leeds Beckett University.

**Matthew Maycock,** PhD, is a Senior Lecturer in Criminology at Monash University and was previously Baxter Fellow in the School of Education and Social Work, University of Dundee and Visiting Fellow at the Centre for Gender Studies, Karlstad University.

**Rosie Meek** is a Professor of Criminological Psychology at Royal Holloway, University of London.

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*Edited by James Woodall, Matthew Maycock and Rosie Meek*

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# INTRODUCTION

*James Woodall, Matthew Maycock and Rosie Meek*

For centuries, prison health has traditionally been shaped by a biomedical perspective emphasising the prevention and treatment of disease. Even in the past few decades, critiques of prison health services have highlighted a reactive and inefficient system still grounded in the medical model of care. More contemporary views of prison health have since emerged, shifting beyond the traditional medical model to embrace a broader, more inclusive social model of health that also incorporates considerations of wellbeing within prison settings. This perspective recognises the wider determinants of prisoner health and wellbeing, including social, psychological and environmental factors. Additionally, there is growing evidence that the health of people in prison can often have a significant impact on the health of those in community settings (Liu et al., 2024). *Prison Health and Wellbeing*, as a book, reflects this evolving understanding by capturing how people in prison are increasingly conceptualised in more empathetic and holistic terms. While it is clear that further progress is needed, the book highlights the breadth of issues affecting prison health and demonstrates a more comprehensive and human-centred approach to understanding wellbeing in custodial settings.

*Prison Health and Wellbeing* is a multi-disciplinary edited volume that brings together contemporary insights into the broad spectrum of health and wellbeing issues in custodial settings. Drawing on research, professional practice and lived experience, the book offers a timely and nuanced exploration of how health is both experienced and delivered within prison environments across different international contexts. It reflects growing recognition

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that prisons are not just places of punishment but also spaces where complex health needs converge – and where the provision of care is often constrained by systemic, cultural and logistical barriers.

Across 12 chapters, the book is structured into three thematic parts. Together, they explore the interplay between institutional systems, diverse health needs and rehabilitative approaches. This tripartite structure allows for a layered understanding of the prison health landscape – starting with the macro-level systems that govern access and delivery, moving into specific populations and conditions and concluding with approaches to rehabilitation and wellbeing that seek to foster resilience and personal growth even within carceral boundaries.

### Part I: structures, systems and access

The first part addresses how healthcare is organised and delivered within prisons, foregrounding the structural and institutional factors that impact both access and quality. Sheard and Canvin's chapter identifies local workforce cultures, continuity of medication and short lengths of stay as key influences on primary care quality in English prisons. Walton and colleagues explore the growing importance of adult social care, pointing to unmet needs, inequities and a lack of robust monitoring frameworks in England and Wales. Gonçalves and co-authors provide empirical data from Geneva, showing high demand and significant barriers to external healthcare access. Finally, Lundeberg and Smith offer a critical lens on prison health in a Nordic welfare state, revealing how even in well-resourced systems, mental health support for women can be compromised by gendered assumptions, isolation practices and uneven service provision.

### Part II: specific health needs and populations

This part turns to the lived realities of specific groups within the prison population, whose health and care needs are often neglected or misunderstood. Toohey examines the interface between cognitive disability and mental health among incarcerated Australian women, highlighting how systemic disadvantage and trauma intersect with poor service provision. Armstrong, Ricciardelli and Johnston investigate how correctional work shapes workers' sense of self and reverberates through their personal and family relationships, revealing patterns of strain, disconnection and resilience. Antojado critiques mainstream trauma-informed care models and introduces a 'queered' approach rooted in lived experience and intersectional practice. Abbott and colleagues explore the vital role of midwives and the challenges

of providing compassionate, non-judgemental maternity care in prison settings. Vaswani examines the phenomenon of disenfranchised grief among young male prisoners, highlighting how incarceration compounds emotional trauma. Smoyer offers a powerful and unusual lens on health and control by focusing on the prison toilet as both a physical and symbolic site of bodily autonomy, dignity and relational power.

### Part III: rehabilitation and wellbeing

The final part focuses on practices and interventions that promote psychological, emotional and social wellbeing in carceral settings. Schreeche-Powell draws on theoretical frameworks to examine the role of peer support in mitigating the psychological "pains of imprisonment." Baybutt, Waldegrave and Codd explore the concept of "ageing well" in prison, drawing attention to the overlooked and growing population of older prisoners, whose complex needs call for age-responsive policies and practices. Murray and colleagues present a case study of a sport-based educational programme for politically affiliated prisoners in Northern Ireland, showing how it enhances wellbeing, soft skills, and self-reflection, and offers scalable, low-cost opportunities for rehabilitation.

Together, these chapters offer a comprehensive, critical and compassionate account of prison health and wellbeing. Future directions for research in this area include further work to centre the voices of those with lived experience of prison settings. Additionally, given the significant and problematic overrepresentation of Indigenous communities in prison settings, particularly in jurisdictions such as Australia and Canada, future work in relation to the particular health needs and experiences of Indigenous communities in prison would greatly enrich this field of research. The legacies of time in prison for the health and wellbeing of those passing through prison systems, for life expectancy and health outcomes in the community following release, would also be a fruitful area of future research. Finally, while this collection includes insights into the health and wellbeing of people in prison in a diverse range of jurisdictions, a great diversity of insights is needed from many jurisdictions. This book reflects wider trends in justice health and wellbeing research that have tended to focus on jurisdictions in the Global North. Future work in a greater diversity of jurisdictions and robust, independent peer-reviewed research from countries within the Global South would greatly enhance the field of research relating to prison health and wellbeing.

To conclude, by centring the voices and experiences of those working in and affected by the prison system, this book aims to inform policy, inspire reform and contribute to more humane and effective approaches to health

and care in custody. It is a vital resource for researchers, practitioners, policymakers and anyone interested in challenging health inequities and improving outcomes for people in prison.

## Reference

Liu, Yiran E. et al. (2024) Mass incarceration as a driver of the tuberculosis epidemic in Latin America and projected effects of policy alternatives: A mathematical modelling study. *The Lancet Public Health*, 9(11), pp. e841–e851.

# PART I

# Structures, systems and access

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# 1

# WHAT ARE THE MAJOR FACTORS THAT INFLUENCE THE QUALITY OF PRIMARY CARE IN ENGLISH PRISONS?

## Headline ideas from a mixed-methods study

*Laura Sheard and Krysia Canvin*

### Primary care in prison

People in prison have significantly higher levels of long-term health conditions, mental illness, infectious diseases and substance use problems than their peers in the community (Stürup-Toft et al., 2018; Kinner and Young, 2018). Additionally, people in prison are likely to be disproportionately affected by having risk factors for non-communicable diseases (Thomas et al., 2016; Wangmo et al., 2016) and to have poorer health outcomes in general (Wilper et al., 2009). Research about prison healthcare tends to concentrate on mental illness and substance use for men and on self-harm, pregnancy and childbirth for women. Despite the high burden of disease in the prison population, there are relatively few studies which focus on the delivery or receipt of primary care services in a broad sense or about common conditions seen in primary care everyday such as asthma, diabetes and high blood pressure. An outlier is a 2008 qualitative study (Plugge et al., 2008) which sought to understand the experience of female patients engaging with primary care in two women's prisons in the South of England. The study found difficulties in access to both care and medications with a poor attitude displayed by some healthcare professionals. A more recent study with men in prison, also in the South of England, found that male patients valued general practitioners (primary care providers) who listened to them and a positive relationship between patient and clinician was said to facilitate better access (Quinn et al., 2018). It is important to note that there are marked differences in the delivery of prison healthcare between various countries due to factors related to policy, funding, infrastructure and notions of carceral punishment.

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The prison estate is viewed as a difficult environment for healthcare professionals to deliver care. In England, these challenges include overcrowding, outdated surroundings in which to practice, security concerns and difficulty attracting and retaining healthcare staff. A recent qualitative study published by the authors of this chapter found that chronic understaffing was the overriding factor that significantly influenced the quality of and access to healthcare in prisons across the North of England (Sheard et al., 2023). We found that understaffing often led healthcare provision in many prisons to become reactive and crisis-led, leading to a situation of continual firefighting. Other authors (Ismail, 2020a) have made the connection between the 30% drop in frontline prison officer (prison guard) numbers since 2010 in England and the indirect negative impact this has had on patient access to healthcare appointments. The shortfall in prison officer numbers means a lack of escorts for appointments within the prison (from cell to healthcare department) and for transfer outside the prison to hospital outpatient appointments or the Accident & Emergency department (Emergency Room) (Davies et al., 2020). The prison healthcare system has been heavily impacted by the COVID-19 pandemic (Canvin and Sheard, 2021). Most healthcare services in English prisons were suspended or restricted towards the start of the pandemic and this has impacted patients by leading to delayed diagnosis of new conditions, exacerbating existing conditions and increasing mental health needs (Wainwright et al., 2023).

As part of a large, multi-disciplinary team, we conducted a large mixed-methods research programme which ran from August 2019 to July 2022. The aim of our programme was to understand what factors most significantly influence the quality of primary care in prisons in the North of England, alongside identifying the gaps and variations in care. In this chapter, we look to understand the quality of prison primary care in a broad sense by integrating findings from across the mixed-methods programme of research.

## Stages of the research

The research programme comprised five stages. We analysed each stage separately and, as such, produced discrete findings. Below, we briefly describe these findings alongside the methods in order to provide context.

### *Stage one: scoping review*

We undertook a scoping review of the international academic literature on the development and selection of quality indicators for primary healthcare in the prison setting, published as Bellass et al. (2022). Our inclusion criteria were broad and we included articles using any methods, any health condition

and any country. We excluded articles relating to community criminal justice settings and transitions from prison to community. We searched six electronic databases for articles published in English between 2004 and 2021 and supplemented this by hand searching four key journals and performing key author searches and forward and backward citation tracking. We then undertook a qualitative synthesis of eligible articles.

We included 15 articles in the review (1271 records screened, 24 underwent a full text review). The literature was overwhelmingly from the United States. We found no articles that included patient representation and stakeholder involvement and rigour in the selection of quality indicators varied. We found that limited or poor recording and coding of healthcare data in prisons represents a major challenge to conducting performance measurement in the prison setting, as well as preventing comparability between prison and community populations.

### *Stage two: stakeholder consensus process to identify quality indicators*

We generated a shortlist of relevant quality indicators using a three-step, iterative process: First, we identified and screened candidate quality indicators from guidance and wider literature, resulting in a list of 76 indicators. Second, we hosted a stakeholder consensus panel to perform shortlisting and selection. We asked delegates to rank indicators on their potential for significant patient benefit (high, medium or low). Third, the research team internally reviewed and refined the indicators, leading to a total of 30 indicators which covered communicable disease, drug misuse, mental health, long-term conditions, prevention and screening.

### *Stage three: qualitative interview study about perceptions of prison healthcare*

We conducted a qualitative interview study between November 2019 and March 2021. We recruited participants via patient and public involvement partners (for people in prison) and through third sector healthcare providers (for staff). We interviewed 21 people who had been in prison and were now subsequently living in the community, including men and women from a range of different prisons and 6 people from an ethnic minority. We interviewed 22 healthcare staff who worked in a variety of roles across both the male and female estate. Interviews were on average about 40 minutes long and we conducted almost all by telephone or video call. Analysis involved mapping interview data onto a four-level quality improvement matrix covering individual, team, organisation and wider system levels (Ferlie and Shortell, 2001).

We found a range of barriers to and facilitators of high-quality care operating across all levels of healthcare organisation and delivery. In particular, understaffing and a dependence on locum clinicians undermined high-quality healthcare, leading to the service in some prisons becoming reactive and crisis-led. Relatedly, unreliable communication processes and pathways exacerbated by staffing issues led to frustration for both patients and staff. We published these findings in the British Journal of General Practice (Sheard et al., 2023). Patient and staff perceptions of the quality of prison healthcare were multi-factorial and complex. They identified organisational issues and features of the wider system that in turn influenced how teams and individuals related to each other and their experience of delivering or receiving healthcare.

### *Stage four: quantitative analysis of quality indicator achievement using routinely collected data*

We took anonymised routinely collected electronic primary care data from ~25,800 healthcare records from 13 prisons in the North of England and subjected them to repeated cross-sectional analyses. We measured achievement against the 30 quality indicators (identified in stage two) over a three-year period (April 2017 to March 2020) and explored associations between achievement of indicators and individual and prison characteristics. Explanatory variables included prison category, age, gender, ethnicity and length of stay. We produced descriptive statistics for each indicator by year for each of the explanatory variables and then developed multi-level logistic regression models for each indicator to explore associations with achievement.

The results were published in the journal eClinicalMedicine (McLintock et al., 2023). There were marked variations in the quality of prison primary care and these spanned different domains including indicators that reflected prison population needs (e.g. medicine reconciliation – accurately listing current medicines upon admission) and those reflecting more general primary care needs (e.g. diabetes care). There was improvement over time for several indicators: Hepatitis B vaccination uptake had increased while gabapentinoid (opiate) prescribing had reduced. Conversely, for other indicators, overall achievement had declined. This was the case for antipsychotic monitoring, which had declined and opioid prescribing which had risen. Short lengths of stay were frequently associated with lower achievement across long-term conditions and screening domains. Wide variations between prisons' achievement were poorly explained by differences in prison population characteristics and there were no consistent patterns in achievement by gender, age or prison category.

### *Stage five: integration of findings*

We held three sequential online stakeholder workshops between October 2021 and January 2022 with predominantly commissioner and clinician delegates. In the first workshop, we presented integrated findings from stages one through to four to 28 stakeholders. They were particularly interested in issues pertaining to opioid prescribing and women's health. In the second workshop, ten stakeholders rated the importance of different indicators and discussed the prison healthcare tendering process. In the third workshop, three stakeholders gave their opinions on the applicability of implementation strategies put forward by the research team, e.g. audit and feedback.

## Ideas of interest

Towards the end of the project, we looked across all research stages to derive headline ideas of interest that were grounded in the empirical data but were more discursive and expansive than the discrete findings from individual stages. To do this, we adopted the approach of 'telling a story' using our data, rather than descriptively reporting straightforward and potentially disparate facts about our topic (Sheard, 2022). This involves employing an interpretative approach to understand the bigger picture of what is resident across multiple datasets. We identified three overarching, interrelated ideas about factors that shape the quality of prison healthcare in England. We predominantly draw upon our qualitative (stage three) and quantitative (stage four) research but include findings from other stages where appropriate.

## Prison healthcare is highly variable and likely driven by the organisation and culture of individual prisons

### *Variability in quality is a feature of healthcare in general*

Variability in quality of healthcare is a persistent problem that relates to health inequalities and is seen in most healthcare sectors and settings across the globe. Healthcare organisations, such as hospitals, which are of a similar size, patient turnover and level of resource/expenditure, can have highly variable outcomes for patients. Stark variation can be seen even between two services in a similar geographic area that deliver the same treatment pathway to patients. A qualitative study in the North of England (Hughes et al., 2020) compared two similar services which had significantly differing outcomes for elective hip and knee replacement surgery. The study found that clinical autonomy, distributed leadership, team resilience and strong communication between all levels of staff were key factors that enabled excellent care to be delivered. Variations between similar services are also common in primary care (Willis et al., 2017). However, there is little previous research which has

looked at variations of care in the prison setting. One study looked at the prison prescribing for TB, HIV, Hepatitis C (HCV) and opiate substitution treatment (OST) across 11 federal states in Germany (Müller et al., 2017). TB and HIV treatment were considered to be adequate, but HCV treatment was considered low and OST treatment highly variable.

### *Variability in the quality of prison healthcare may be attributable to the culture of individual prisons*

Correspondingly, our analysis of routinely collected data (stage four) shows that variations are also present in prison primary care and cannot be solely attributed to differences in recorded prison population characteristics. Our quantitative analysis of routinely collected data (stage four) demonstrated that achievement of indicators varied widely with no clear pattern by type of individual indicator or by clinical domain (e.g. diabetes, asthma, communicable disease). We identified improvement over time for several indicators including increased uptake of Hepatitis B vaccination and influenza immunisation and reductions in gabapentinoid prescribing. Yet, achievement declined over time for opioid prescribing which rose and a reduction in monitoring of patients prescribed antipsychotic medication. We found that overall achievement in prisons was low when compared to community primary care – this could be seen for glycaemic control for diabetes. We found no clear overall trends in relation to achievement by age, gender, ethnic group or prison category.

Overall, the extent of variation between prisons was incompletely explained by differences in prison population characteristics. Our analysis examined indicator achievement in 13 prisons where healthcare was delivered almost entirely by one healthcare third sector, non-profit healthcare provider (Spectrum CIC), which has high-quality care as a core organisational goal. Additionally, all 13 prisons were located within the North of England. To find such variability of achievement for healthcare indicators across 13 prisons delivered by a single care provider suggests that behavioural and cultural factors inside each prison gate have a significant role in influencing outcomes. This is consistent with what staff and patient participants told us in the qualitative interviews.

Interview participants in stage three spoke about variability in relation to access to healthcare (over and above the quality of it). People in prison suggested that access to healthcare often depended on how accommodating and efficient prison officers were at enabling a patient's request for a healthcare appointment and then unlocking the patient from their cell in time to attend it. This access request and attendance scenario was often perceived as being contingent on a patient's prior behaviour and whether prison officers considered them to be 'trouble.' These demonstrable barriers meant that

whether a patient even got through to see a clinician was highly variable not only between prisons but dependent on which prison officers were on shift and whether the prison officer workforce was appropriately staffed or not. Healthcare staff participants spoke about difficulties persuading prison officers that a patient needed healthcare access and a situation which was often challenged and/or delayed was a request to transfer a patient out of the prison to an Accident & Emergency department at a hospital.

Relatedly, many prisons have a high 'did not attend' (DNA) appointment rate, as expressed by both people in prison and staff participants in our interviews. This is reflected in a nationally representative figure of English prison healthcare appointments having a 20 to 30% DNA rate (Independent Monitoring Boards, 2018), compared to a consistent 5% DNA rate in community primary care (NHS England, 2019). Additionally, 40% of hospital outpatient appointments made for people in prison are not attended (Davies et al., 2020). The variability in access to healthcare for patients in prison seems to be largely dependent on factors outside the control of the healthcare provider/healthcare department and appears to be related to the localised prison officer workforce and their relationships with individual patients and the healthcare team.

### The incompatibility of prison and community systems/ processes impedes consistency and continuity of care

#### *Prison population 'churn' combined with inadequacies in the community-prison interface have implications for continuity of treatment*

There is a high rate of recidivism in the UK prison population and consequently responsibility for the healthcare of many patients regularly passes between prison and community healthcare teams (Bellass et al., 2021). The period of time immediately after a person is released from prison – and in particular the first week – is known to be particularly challenging and represents a much higher risk of hospitalisation when compared to the general population (Wang et al., 2013). Several key barriers impact on high-quality continuity of care between prison and the community and back again, and we saw these represented both in our data and the literature.

The management of long-term conditions is often disrupted by patients moving between community and prison, impacting on the continuation of community prescriptions and therefore important medication (Wright et al., 2021). Our qualitative interviews (stage three) shed further light on the implications of the prison-community interface. Continuity of medicines from community to prison was highlighted as a concern by both patient and staff participants and it was noted how people entering the prison on a Friday often encountered problems relating to the continuation of existing

medications. The issue of opioid prescribing was noted as a cause of tension between healthcare staff and people in prison. Some patients perceived that they were not being treated as individuals and were unfairly labelled as drug seekers. Regarding the poor interoperability between prison and community clinical systems, staff participants discussed the process of requesting a patient's summary care record from their community GP and how some practices may not recognise the urgency contained within this request. More positively, it was detailed by staff participants how a thorough and detailed screening process at the initial reception clinic was beneficial in identifying the health needs of individuals newly received into prison. However, at the end of the patient journey, there was concern expressed by some staff that if a patient is not registered with a community GP, then care simply ends when the patient leaves the prison.

Conversely, opioid prescribing exists on what could be called a 'carousel' whereby prison clinicians aim to reduce their prescribing to lower the risk of diversion inside the prison only for the patient to then approach their GP in the community to reinitiate their opiate prescription after release (Bellass et al., 2021). We measured the proportion of the prison population prescribed opioids during an eight-week period and found that 11.5% of people in prison were prescribed any opioid compared to 12.8% of community general practice patients, which is a favourable and similar comparison. However, when we looked at strong opioids only we saw that prescribing of these drugs in the prison (8.7%) was much higher when compared to the community (0.85%). In our stage five workshops, delegates themselves proposed that one of the main influential factors regarding the quality of prison healthcare related to the opioid prescribing carousel between prison and community. They argued that there needed to be better communication channels between community and prison GPs to overcome this challenge.

In our quantitative analysis of routinely collected data (stage four), we looked at the achievement of one highly specific prison-community interface indicator: 'the proportion of new receptions to prison who have been asked for consent to transfer medical records from GP to prison healthcare' ('new receptions' means people recently entering the prison). Of the people who were eligible for this indicator, 70% of them were asked for consent to transfer medical records, and this represented a fourfold improvement over between 2017 and 2020. Interestingly, this indicator had one of the highest variations between prisons that we found in our dataset: a 337-fold difference. Our interpretation is that whether people entering prison are asked for consent to transfer their community medical records is likely highly dependent upon individual prison policies. Our stage five workshop delegates also identified the limitations of community general practice summary care records. They thought this situation might be difficult to improve unless the