Health care in secure environments

The provision of health care in secure environments consists mainly of providing primary care, although the health needs of the prison population differs significantly from that of the population as a whole in the incidence of both psychiatric and social morbidity.[1]

Figures published by the prison service and Marshall *et al*[2] illustrate the problem:

- 54% of prisoners were found to have a physical health problem or disability at reception. The commonest physical illnesses were asthma and epilepsy.
- 90% of people entering prison (150 000 people) had a mental health problem including substance misuse.
- 29% of female prisoners, 24% of male prisoners and 4% of young offenders reported having injected drugs at some time.
- 10% of adult prisoners who have injected drugs had hepatitis C antibodies.
- 7% of the prison population had a serious mental health problem.
- Four times as many people smoked in prison than in the community
- 13% of prisoners had asthma.
- 20% of women in prison asked to see a doctor or nurse every day.
- Untreated dental disease was four times greater in prison compared to the rest of the population.

The Department of Health and HM Prison Service published *Developing and Modernising Primary Care in Prisons*[3] in 2002 and stated that:

> *'Good primary care is the essential foundation on which any good healthcare system is built and this is especially the case in prison settings. A well trained and effectively managed primary healthcare team can make a tremendous contribution to improving the overall quality of health and healthcare services for prisoners.'*

Prisoners have the right to expect and receive the same quality of health care as patients in the community. In 1996, the Chief Inspector of Prisons recommended in the publication *Patient or Prisoner?*[1] that prison healthcare should transfer from the Home Office to the Department of Health. With this in mind, in September 2003 the government announced the transfer of responsibility for funding and commissioning healthcare from HM Prison Service to primary care trusts (PCTs). Over one-quarter (28%) of PCTs have a prison in their patch and the transfer of responsibility is due to be completed by April 2006.

Since 1999 all doctors providing primary health care in prisons must possess the Joint Committee of Postgraduate Training in General Practice (JCPTGP) certificate. A report from the working group of three medical Royal Colleges highlighted the problems of doctors working in prisons. Recruitment was a real problem and prison doctors were sometimes found to be inadequately trained and often working beyond their limits and capabilities.[4]

The Diploma in Prison Medicine was developed in 1996 as a conjoint diploma of the Royal College of General Practitioners (RCGP), Royal College of Physicians (RCP) and Royal College of Psychiatrists (RCPsych). This was delivered by the Trent Deanery at the University of Nottingham and was developed with the support and guidance of the examination steering group chaired by Professor Dame Lesley Southgate.

The diploma programme was only available to doctors working in the prison service. Initially they were full-time prison doctors but over last 2 years of the diploma, due to the changing workforce in prisons and the gradual integration of prison health within the NHS, the doctors entering the course were predominantly GPs with a sessional commitment in prisons. Fifty doctors have successfully completed this diploma.

The course had 10 5-day residential modules. Over the last 2 years with the change in intake from full-time prison doctors to GPs the course was changed to a shorter 3-day residential module with a larger distance learning component.

The delegates on the diploma course had frequently requested university accreditation for the diploma, so that it could be used as part of their educational portfolio to contribute to a postgraduate diploma or masters degree. With this in mind a multiprofessional masters in Primary Healthcare in Relation to Secure Environments was developed. This has been validated by the University of Lincoln and represents a successful collaboration between the Trent Multiprofessional Deanery, Lincoln University and the RCGP. The course has also been endorsed by the RCP. This is the only multiprofessional generic educational course for healthcare professionals working in secure environments in the UK and offers a range of options for students in a multiexit modular structure, enabling anything from a single module to be taken up to a complete masters degree.

The collaborative approach has enabled the Trent Deanery's expertise and reputation in prison healthcare education, the University of Lincoln's innovative approach to the design and delivery of postgraduate programmes along with the educational resources and expertise of the RCGP to develop a course that will meet the wide-ranging needs of health professionals using a blended learning approach.

The programme builds on the diploma in prison medicine, but the rationale for the course content and learning outcomes of the Masters, Diploma and Certificate in Primary Healthcare in Relation to Secure Environments was based on the Durham training needs analysis.[5] This analysis identifies high, medium and low priority needs and further subdivides these into clinical and

Table 1. Primary Healthcare in Relation to Secure Environments.

60 M Level Credit Points PG Certificate	Legal and ethical aspects of custodial healthcare 12 CATS	Public health 12 CATS	Women prisoners and young offenders 12 CATS	Mental health and learning disability 12 CATS	Management of substance misuse (1) 12 CATS
120 M Level Credit Points PG Diploma/DMS	Forensic psychiatry 12 CATS	Occupational health 12 CATS	New ways of working 12 CATS	Sexual health and HIV medicine 12 CATS	Management of substance misuse (2) 12 CATS
180 M Level Credit Points Masters	Evidence based practice and research 12 CATS Dissertation or extended portfolio — related to area of Professional Practice 48 CATS				

patient contexts. The needs were identified through semistructured interviews of clinicians working in secure environments.

The programme incorporates several specialist modules including both parts of the RCGP's Certificate in the Management of Drug Misuse.

The first intake of students on the new masters course commenced in October 2005. Five students have enrolled, of which two are from Singapore. There are four doctors and one nurse. We anticipate increasing the intake significantly for the next academic year and aim for 20–30 students for 2006–2007. Details of the masters course are shown in Table 1.

In parallel with the development of the masters course, a working group of Doctors Working in Secure Environments has been established at the RCGP to support, develop and promote the interests of GPs working in secure environments. This group contains representatives from the BMA, RCGP and doctors working in secure environments.

The RCGP Doctors Working in Secure Environments Group has supported the development of an induction programme for healthcare staff intending to work in secure environments. This multiprofessional course is being developed by the University of Lincoln in partnership with the RCGP. The programme will consist of the equivalent of 5 days study, 4 of which will be delivered by distance learning and a 1-day event at the conclusion of the programme at Lincoln University. Topics to be covered in the induction course include:

- advocacy and the criminal justice system;
- the consultation in secure environments;
- mental health;
- treatment approaches including hunger-strike management and consent;
- substance misuse;
- self harm and suicide. Assessment of risk;
- forensic psychiatry;
- healthcare team and multiprofessional working;
- genitourinary medicine including HIV; and
- clinical governance and maintenance of good practice.

It is anticipated that the induction course will be launched by mid 2006.

CONCLUSION

The principle of equity that those placed in secure environments are entitled to the same level of health care as the rest of the community, requires the development of a firm educational framework for health professionals together with a considerable amount of infrastructural change to ensure that the skills of health professionals can be utilised in a seamless primary healthcare system.

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