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England



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Europe

# **Proceedings of the Joint WHO/PHE Health & Justice International Conference and Regional Engagement event**

Copenhagen, Denmark, 3-4 November 2016

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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## Glossary of abbreviations

|          |  |
|----------|--|
| BBV      | Blood borne viruses (HIV, Hepatitis B and C)                                   |
| CGLPL    | Contrôleur Général des Lieux de privation de Liberté                           |
| CPT      | Council for the Prevention of Torture  |
| CVD      | Cardiovascular Disease   |
| ECDC     | European Centre for Disease Prevention and Control                             |
| EEA      | European Economic Area   |
| EMCDDA   | European Monitoring Centre for Drugs and Drug Addiction                        |
| EU       | European Union   |
| GPs      | General Practitioners  |
| ICRC     | International Committee of the Red Cross                                       |
| MDR-TB   | Multi-drug resistant tuberculosis  |
| MSM      | Men who have sex with men  |
| NCDs     | Non communicable diseases  |
| NOMS     | National Offender Management Services (England and Wales)                      |
| OST      | Opiate substitution treatment  |
| PHE      | Public Health England  |
| UK CC    | UK Collaborating Centre for the WHO Health in Prisons Programme                |
| WEPHREN  | WHO Europe Prison Health Research and Engagement Network                       |
| WHO HIPP | WHO Health in Prisons Programme  |
| XDR-TB   | Extensively drug resistant tuberculosis (rare type of multi drug resistant TB) |

## Foreword



For the fourth successive year, PHE have co-hosted an international expert meeting with WHO Europe's Health in Prison Programme. This year, we held the event in the headquarters of WHO Europe, in UN City in Copenhagen. In many ways, this was symbolic of how the prison health programme is a core component of wider WHO programmes to reduce premature mortality, improve health and tackle health inequalities – 'to

leave no one behind'.

Internationally, people in prison often experience significant health and social inequalities, prior to and after, as well as during, imprisonment. But perhaps the starkest inequality of all is the risk of premature mortality which is much higher among prisoners than the general population, for both natural cause as well as self-inflicted deaths. And this is not limited solely to 'resource poor' countries. Indeed, the contrast in some Western countries between risk of mortality among people in prison compared to the general population is all the more striking because many such countries espouse a principle of equivalence of healthcare for prisoners and adhere to the WHO principles outlined in [Good Governance for Prison Healthcare in the 21st Century](#).

The causes of such differences in all cause mortality are complex but include environmental as well as personal factors. People who come into prison have often been 'under-served' by health services prior to incarceration, including poorer access to health programmes designed to detect signs of risk factors for chronic illness before they manifest as symptomatic disease. Cardiovascular disease is now the leading cause of death among prisoners in England & Wales, a fact often attributed to our ageing prison population. While undoubtedly true, this statement obscures the fact that many people dying in prison categorised as 'older prisoners' include people in their fifties and sixties for prison populations, 50 years or older is the working definition used for 'older prisoners'. Self-inflicted death rates in prison are also rising, in some countries (including the UK) at an alarming rate. Causes are again complex but consideration of how people with acute mental health needs are identified and managed in prison needs a 'whole prison approach' and delivering interventions which take account of the prison environment as well as the needs of the prisoner requires adaptations of standard psychiatric and psychological therapeutic approaches.

Finally, in both physical and mental health improvement programmes, there is much to be done yet in increasing the role of peer support in delivering diagnostic and well as

therapeutic interventions. Indeed sadly in many member states, the only resource increasing in our prisons are prisoners.

This conference included 'state of the art' presentations from a broad range of international experts across health & justice organisations as well as patient and prisoner advocates. The programme covered aspects of preventing as well as learning from both natural and self-inflicted deaths and considered physical as well as mental health issues, including drug & alcohol dependence, chronic and acute illness, and infectious diseases like TB and HIV. The event also promoted two innovations PHE are leading in collaboration with the WHO Regional Office for Europe - the establishment of a new collaborative research network to improve the evidence-base informing policy & practice (**WEPHREN**), and the Minimum Public Health Dataset, which through systematic data collection across Member States will enable comparisons to highlight both good practice and areas for improvement internationally.

Finally, I would like to dedicate this report to the memory of the late Judge Michael Reilly, Chief Inspector of Prisons in the Republic of Ireland who was a key note speaker at this conference. He sadly passed away suddenly and unexpectedly shortly after our time together in Copenhagen. Judge Reilly was a passionate advocate for prison reform and a champion of the rights and dignity of people in prison, nationally and internationally. We hope that this report will form a fitting tribute to him and in some small way contribute to continuing his good work.



Dr. Éamonn O'Moore,

National Lead for Health & Justice PHE and Director of the UK Collaborating Centre to the WHO Health in Prisons Programme (European Region).

December 2016.

# Summary

Public Health England's Health and Justice team, in their role as the UK collaborating centre to the WHO Health in Prison Programme (UKCC WHO HIP), co-produced an international conference with the WHO Europe Regional Office (Copenhagen) at the UN City in Copenhagen, Denmark, in early November 2016 on the theme of Deaths in Custody.

Led by Dr. Éamonn O'Moore, the PHE team included Dr. Jo Peden and Sunita Stürup-Toft from the National Health & Justice team, and Dr. Emma Plugge from the University of Oxford working with PHE on WEPHREN, an international prison health research network.

The conference attracted 96 participants from the 53 WHO European Region member states, as well as other countries such as the United States of America, Canada, Chile and Morocco.

This report summarises and synthesises the proceedings and outcomes of the international conference on Health in Prisons in Europe, including highlighting its contribution to [PHE's Global Health Strategy](#).

## The programme

The aim of the programme was to share good practice internationally to improve the quality of prison healthcare with a focus on deaths in custody, including both self-inflicted deaths and deaths due to natural causes (encompassing chronic illnesses and infectious diseases). This is in response to the observed rise in deaths in custody in many states, especially in Western Europe, attributable in part to the aging prison population (natural cause death) but of deep concern is the rise in suicide in prison. Both causes of death are amenable to interventions.

The two day [programme](#) comprised of the international conference and a regional consultation event, which included discussion on the launch of the WHO Europe Prison Health Research and Engagement Network ([WEPHREN](#)), the implementation of the [Minimum Public Health Dataset for Prisons in Europe](#) as well as country and organisational updates on the theme of deaths in custody.

## International conference

The first day of the programme co-chaired by Dr. Éamonn O'Moore, PHE & Director of the UK Collaborating Centre, and Dr. Lars Møller from WHO Europe. The opening address was given by Dr Gauden Galea, WHO Regional Office for Europe's Director for the Division of Noncommunicable Diseases and Promoting Health through the Life-Course.

International experts presenting included Dr Ingrid Binswanger (USA), Dr Ruth Elwood Martin (Canada), Dr Famil Mammadov (Azerbaijan), Dr Meykin Djunushova (Kyrgyzstan), Ms Lyuba Azbel (Eastern Europe and Central Asia), as well as justice experts Judge Michael Reilly (Republic of Ireland) and prison governor Mr. Are Høidal (Norway) Dr Marzena Ksel (European Committee for the Prevention of Torture (CPT)) and Anne-Sophie Bonnet (Contrôle Général des Lieux de Privation de Liberté (CGLPL)).

The programme included presentations from international experts on the ageing prison population and interventions to identify and treat illnesses related to cardiovascular disease:

- premature mortality associated with mental health and substance misuse (including self-inflicted deaths and drug-related deaths)
- interventions to improve professional development on these issues in Central Asia
- work on tuberculosis control in Azerbaijan
- the public health impact of the physical environment of the prison on mortality

## Regional consultation event

The second day was a Regional consultation event of member states led by the WHO and chaired by Mr. Stefan Enggist from the Federal Department of Home Affairs and Public Health in Switzerland. There were presentations and discussions on specific initiatives including the roll-out of the WHO Minimum Public Health Dataset for Prisons survey; the launch of the WHO Europe Prison Health Research and Engagement Network (WEPHREN); and a continuation of the conference theme of deaths in custody with a keynote presentation from Professor Seena Fazel from the University of Oxford on suicide in prisons and post-release.

Further country and organisational updates were given by Dr Bobby Cohen from the United States of America, Dr Olivier Sannier from France, Dr Éamonn O'Moore on behalf of the United Kingdom, Brenda van den Bergh from DIGNITY, Alison Hannah from Penal Reform International, Jan Malinowski from the Pompidou Group of the Council of Europe, Dr Lesley Graham from the Scottish Health Service and Dr Carole Dromer from the International Committee of the Red Cross.



## Outputs

The following products were agreed at the conference which will be taken forward under PHE's leadership as the UK CC to the WHO HIPP:

- the WHO Europe Prison Health Research Network (**WEPHREN**)
- the **WHO Minimum Public Health Dataset** survey tool has now been sent to country focal points across the WHO European Region, a tool that was beta-tested by the UK under PHE's leadership. PHE's UKCC WHO HIPP will continue to support this survey process and the subsequent data analysis and commentary.

# 1. Introduction

In 1995, the World Health Organization (European Region) and the UK established a network for the exchange of experience in tackling health problems in prisons. From this network emerged the WHO Health in Prisons Programme (WHO HIPP), which now includes 47 member states of the 53 from the WHO EURO region. WHO Europe is the only region to have a prisons programme, therefore providing global leadership in the area of Health and Justice. HIPP's main activity is to give technical advice to member states on:

- the development of prison health systems and their links with public health systems
- technical issues related to communicable diseases (especially HIV/AIDS, hepatitis and tuberculosis), illicit drug use (including substitution therapy and harm reduction) and mental health.

## 1.1 PHE's UK collaborating centre to WHO HIPP

As with some other WHO programmes, the WHO HIPP is supported in its mission by a UK collaborating centre (UK CC). The WHO collaborating centres form part of an institutional collaborative network set up by WHO in support of its technical work. They provide services to WHO at country, regional and global levels and are involved in technical cooperation for national health development. WHO collaborating centres are required to participate in the strengthening of country resources and national health development via information sharing, service provision, research and training.

The UKCC WHO HIPP's contribution to PHE's international activity is acknowledged in [PHE's Global Health Strategy](#).

The PHE UKCC to WHO HIPP works as part of a multidisciplinary health and justice specialist team within PHE which:

- oversees, coordinates and delivers high quality professional input, technical support and advice to the WHO Regional Office in Copenhagen and European partners on a range of health and social care issues
- co-delivers an international conference on prison health annually (London, England 2013, Portlaoise, Republic of Ireland 2014, Bishkek, Kyrgyzstan 2015, Copenhagen, Denmark 2016)
- supports the coordination of work across the WHO EURO region through the Health in Prisons Programme Steering Group, whose membership includes representatives of member States, the WHO HIPP UKCC (PHE), nongovernmental organisations and intergovernmental organisations

## 1.2 Purpose of the programme in Copenhagen

PHE's **Global Health Strategy** recognises that there are challenges affecting us all which require global multi-system approaches. The health and justice agenda is an example of this: improving the health of those in detained settings and the impact of improving health in detained settings on community health and social outcomes is clearly an opportunity to reduce global health inequalities. By working in partnership we achieve not only our own domestic priorities, but also contribute to the public health priorities of others.

The ongoing work of the WHO HIPP UKCC allows an opportunity for PHE to engage on international aspects of health and wellbeing, both around communicable and non-communicable diseases, strengthening future relationships for further global health activity and the potential to develop public health capacity in other countries.

The WHO HIPP UKCC aimed to produce a conference which provided an opportunity for sharing good practice across regional member states and a regional consultation meeting to hear about action already undertaken through the HIPP and consult on new areas of work. The stimulating agenda demonstrated PHE's expertise and leadership in health and justice, its partnership work with other member states and provided an opportunity to learn and develop a shared future for health and justice.

The conference topic was deaths in custody, covering mental health, substance misuse as well as the associated health impacts of an ageing prison population. Deaths in custody are a key concern due not only to the increasing rates across the WHO European region, but also the increased numbers of people in incarceration. The complexity of reducing deaths in custody also requires intensive and effective partnership work between health and justice disciplines. It reflects directly on the human rights approach to access to healthcare in prison as stated in various international conventions and guidance, and most clearly expressed in The United Nations standard minimum rules for the treatment of prisoners, Rule 24: 'Healthcare of prisoners is a state responsibility, and should be of an equal standard to that available in the community, organised in close relationship to the general public health administration'.  
[http://www.unodc.org/pdf/criminal\\_justice/UN\\_Standard\\_Minimum\\_Rules\\_for\\_the\\_Treatment\\_of\\_Prisoners.pdf](http://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf)

## 1.3 Organisation

The events were organised through the UK collaborating centre, PHE's Events team and the WHO Europe office. PHE hosted the conference website ([www.phe-events.org.uk/HJAC16](http://www.phe-events.org.uk/HJAC16)) which was translated into Russian, arranged all registration, and worked together with WHO colleagues to ensure the delivery of the event.

## 1.4 Media engagement

The event was given a social media presence using the Twitter hashtag #prisonhealth with some activity leading up to the conference, tweets during the conference including retweets from wider international colleagues.

## 2. WHO HIPP and PHE conference



The first day of the programme included an international conference co-chaired by Dr. Éamonn O'Moore from PHE and Dr. Lars Møller from WHO Europe, attended by a global delegation focussing on deaths in custody including those related to substance misuse, mental health and natural causes. Delegates were welcomed by Dr. Lars Møller and the opening address was given by the WHO Regional

Director for Europe, Dr Gauden Galea, WHO Regional Office for Europe's Director for the Division of Noncommunicable Diseases and Promoting Health through the Life-Course.

Dr Galea acknowledged that despite appearing at times to be a niche area, prison health was a thriving focus of international work. He expressed his thanks to the international partnerships with academics and countries such as Switzerland and Finland in enabling some of this work. The WHO's Health 2020 strategy (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020>) and the UN's sustainable development goals (<http://www.un.org/sustainabledevelopment/sustainable-development-goals/>) support the importance of prison health and Dr Galea called nations to consider public health in prisons requiring the same efforts in developing an evidence base as wider community health; the work needs to be based in a human rights approach to health. Dr Galea encouraged nations to respond to the WHO Minimum Public Health in Prisons Dataset survey, citing the importance of comparisons between countries to generate support for the advocacy of people in prison.

The hosting country is traditionally given the opportunity to open the conference with an introduction to their prison healthcare system. Lise Nordskov Nielsen from the Danish Prison and Probation Service presented on the structure of the Danish prison service and the fact that custodial sentences were decreasing in Denmark. However, this meant that there was a concentration of difficult and challenging prisoners in prison, changing the pressures on current resources.

Recruitment for mental health remained an issue, particularly as psychiatry and healthcare in prisons are not given as much credence for healthcare professions as a career option.

In 2016 an analysis of the prison healthcare system was conducted in Denmark, posing the question of how to organise prison healthcare in the future and whether the

responsibility of healthcare in prisons should sit under the Ministry of Justice. Other challenges and issues identified by the review included the dispersed nature of prison healthcare teams, the need for skills development, co-operation with community based healthcare, the need to have electronic medical records and the importance of assessing any special need requirements of people in prison on reception.

The recommendations of the review include the need to develop standards of healthcare provision, as well as improving data capture, analysis, and professional development. Plans to bring together a Health and Justice Board may help in driving some of these recommendations forward over 2017.

## 2.1 Session on natural cause mortality, non-communicable diseases and tuberculosis



The morning session was chaired by Dr Lars Møller from the WHO and included presentations on research into deaths in custody as well as practice developments to reduce these deaths. The keynote presentation was given by Dr Ingrid Binswanger, from the University of Colorado, on her work in an addictions clinic and in prisons in the United States.

The USA has a surveillance system on the health of those in prison which facilitates analysis of deaths in custody. Over 12 million people are in contact with the criminal justice system in each year, with cancer being the highest contributor to deaths in custody. In terms of 'external mortality', that is death not caused by disease, suicide is the highest cause of mortality, particularly in remand prisons.

There are considerations to note in regard to the accuracy of the surveillance system which Dr Binswanger highlighted, including changing demographics of the prison population, sometimes small sample sizes in certain comparator groups, as well as appropriateness of those comparator groups and quantifying appropriate denominators.

Dr Binswanger emphasised the need for a robust surveillance system for deaths in custody to improve public awareness in this area and to increase public transparency and trust on addressing the associated issues.

Dr Binswanger highlighted the harmful effects as well as the protective effects of prison. Stress, social isolation, mental health risk, communicable disease exposure, limited autonomy, multiple transitions due to 'churn' (that is the movement of people in and out of prison) and the risk of exposure to violence were balanced against prison being an enclosed and controlled environment, reduced alcohol and drug exposure and

guaranteed healthcare (Dr Binswanger's work has also reported on the disappointment and challenges people face in trying to access healthcare in the community upon release).

A new study by Dr Binswanger and her team, pending publication, compares outcomes for people sent to prison, probation and remand based on 111,000 deaths registered at the National Death Index in the state of Michigan. Preliminary findings suggest that there is a two-fold increase in all-cause deaths for those in the criminal justice system post-release compared to the general population, with a seven-fold increase in suffering a drugs overdose and a two-fold increase in suicide. Whilst in prison, there appeared to be a protective effect with illness mortality in prisons closer to that of the community, and accidental-cause mortality lower than that of the general population.

Dr Binswanger's final thoughts were that surveillance data on deaths in custody was essential to improve public transparency and to empirically inform policies, and that there were huge in-prison opportunities to prevent post-release mortality. The irony of being able to access healthcare in prison more easily than in the community should not support the incarceration of people to improve their health, but should drive forward change and development both in prison and in the community to meet the needs of this under-served part of our community.

### Presentation on non-communicable diseases

Dr Emma Plugge, University of Oxford

Dr Ruth Elwood Martin, University of British Columbia

Dr Emma Plugge spoke about the importance of non-communicable diseases (NCDs) in prisons. Approximately 42% of all NCD deaths globally occur before the age of 70 and socioeconomically deprived groups are disproportionately affected. It is therefore not surprising that NCDs are an important health issue in prisons. She provided evidence on cancer, chronic respiratory disease and diabetes mellitus from Australia, the UK and the USA, showing higher rates of these diseases in people in prison when compared to those in the community. In part this can be attributed to the four main behavioural risk factors: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diet that lead to four key metabolic/physiological changes: raised blood pressure, overweight/obesity, hyperglycaemia and hyperlipidaemia.

People in prison have very high rates of smoking in prison (prevalence in men is 64-92% and 63-85% in women) and of alcohol abuse & dependence prior to imprisonment (18-30% in men and 10-24% in women). When compared to the general population, people in prison in Australia are more likely to meet guidelines for physical activity whereas those in the UK are less likely to meet these guidelines. Obesity is an important issue in men and women in prison in high income countries with prevalence rates as high as 70%.

Finally, Dr Plugge reminded the audience that a whole prison approach is needed if we are to address effectively the issue of NCDs in prisons. A health promoting prison will support prisoners to stop smoking, ensure healthy choices for food, and guarantee daily physical activity. She explained how the concept of decency is key: a decent prison does not crowd people, provide them with poor food or fail to address their addictions.

Dr Ruth Elwood Martin then provided an example of a nutrition and fitness programme developed by and for women in a Canadian provincial medium secure prison; more information can be found at <https://www.inanna.ca/catalog/arresting-hope-women-taking-action-prison-health-inside-out/>. This was an example of participatory research – the inmate research team invited all incarcerated women through word of mouth and posters to an introductory seminar and invited them to sign up for the programme which contained both a nutritional component and a personal exercise component.

For the nutritional component, participants were given the Canada Food Guide and a personalised food chart that enabled them to self-monitor their progress in eating behaviour for six weeks. An educational nutrition PowerPoint presentation was offered to all inmates every Saturday morning during the six-week pilot programme. Interdisciplinary prison staff observed an increased interest and use of the gym equipment during the six-week pilot programme. The gym was frequently used by others doing independent exercise outside of the group circuit classes. The women in prison identified a need for a healthier lifestyle whilst in prison, as many women gained weight due to the high carbohydrate diet on offer, lack of exercise, boredom in prison and drug cravings. The head of the prison noted that in the full four years of the programme, there were no escape attempts, staff assaults or use of force. There were no suicides in this time and only one minor incident of self-harm.

The above presentations emphasised that a whole prisons approach is essential in addressing non-communicable diseases.

### Presentation on physical healthchecks in prisons

Dr Jo Peden, Public Health England

Dr. Jo Peden shared an example of an intervention which aims to prevent cardiovascular disease in prisoners. She described how people in prison suffer significant health inequalities, due to multiple complex needs (including health and social care needs) before going into prison as many come from deprived communities. This means that they are already disadvantaged in terms of their health and the wider determinants of health and often have alcohol and drug dependency issues, as well as complex mental health issues.

Dr Peden presented data comparing the standardised mortality ratio of people in prison against the general population between 2005 to 2014, which showed a significant



difference in the experience of all cause mortality between the two populations. In 2014 the likelihood of mortality in prison was 40% greater than in the general population. In prisons in England, mortality from natural causes is increasing and has been the main cause of death since the end of 2007. However, in the 12 months to September 2016, compared to the same period of the previous year, there has been an increase in all cause deaths in custody by 21% (324 deaths) at a rate of 3.8 deaths per 1,000 prisoners, compared with 3.1 per 1,000 in the same period of the previous year. Self-inflicted deaths up 13% and natural cause deaths have increased by 17%<sup>[1]</sup>. While this has been explained by the increase in the “ageing prison population”, it should be understood that the category of ‘older prisoner’ includes people aged 50 years and older. Therefore, many people dying from natural causes in prison who are among the ‘older population’ are in fact suffering from premature mortality, from preventable diseases, especially cardiovascular disease (CVD).

Dr Peden described the prevention pathway, which she explained is just as applicable in prisons as in the community. There is a need to focus on the key risk factors of CVD and highlights again the importance of a multi-faceted approach targeting behavioural risk factors, such as smoking, high blood pressure, diet, drinking, physical inactivity and high cholesterol and also social and environmental factors.

Dr Peden described the community based intervention programme called NHS Health Checks which is a risk assessment and management programme aimed at 40-74 year olds, targeting the seven main causes of premature mortality in England.

A task and finish group was set up which involved NHS England, National Offender Management Services (NOMS) and Public Health England to look at how the programme could be delivered more effectively in the prison context. Based on the higher levels of need within the prison population and the higher premature mortality the age criteria were widened to include 35 -74 years, therefore capturing detainees five years younger than in the general population. A new criterion was introduced limiting offer of the programme to those incarcerated to two years or more to address challenges in delivering impactful interventions. A further criterion was added to ensure that those incarcerated for less than two years would be registered on release to a GP and then would be picked up in the equivalent community programme to ensure an equal opportunity access the programme.

Dr Peden discussed the key challenges for the programme which included providing uniform high quality delivery, continuity of care after release and ensuring registration with GPs, providing ‘prisonified interventions’, providing healthy dietary choices in a prison setting and adequate physical activity and evaluating the intervention.

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<sup>1</sup> <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2016>

## Presentation on Tuberculosis in prisons

Dr Famil Mammadov, WHO Collaborating Centre on prevention and control of tuberculosis in prisons (Azerbaijan)

Dr Mammadov presented the structure of the prison medical departments in Azerbaijan and statistics on the impact of tuberculosis (TB) on mortality rates in prisons, which has increased 20-fold over the last 10 years. Azerbaijan uses entry screening, mass screening and passive screening as strategies to identify TB cases in prisons. Adherence to treatment into the community setting is supported by non-governmental organisations.

The presentation provoked much discussion about the availability of medications for treating TB. Romania and Azerbaijan reported that the drug bedaquiline was not approved for use in prisons, whereas in Georgia where it is approved, where there have been impressive results in reducing TB cases, anecdotally reported from 457 (in 2012) to 256 (in 2015).

It was acknowledged that HIV is still increasing in this region, linked to the lack of treatment and harm reduction strategies. In Romania, from 2008-2014, the numbers of people in prison diagnosed with HIV increased by five times. Slovenia cited the HIV epidemic as being linked to men who have sex with men (MSM), whilst injecting drug use associated HIV was decreasing. Hepatitis B and C were highlighted as the real challenge in prisons at the moment across the Europe Region. PHE was able to talk about the Blood Borne Virus (BBV) opt-out programme that has been running in prisons from 2014, enabling testing and vaccination (for Hepatitis B) on reception to prison as routine and as a key opportunity for intervention. Italy has also been giving Hepatitis B vaccination actively and has been doing further work on Hepatitis C as a result of their increased migrant population (an increase which also features in their prison population). France is making Hepatitis C treatment free to all prisoners.

The European Centre for Disease Prevention and Control (ECDC) shared information about a two-year systematic review they are conducting on communicable disease in prisons in EU/EEA member states. This work is being steered by an expert panel, chaired by PHE's Dr Éamonn O'Moore, and including international experts in communicable disease control as well as representatives of the Council of Europe, the European Monitoring Centre for Drugs and Drug Addiction and Health without Barriers.

Three macro-areas of interest for the review have been agreed:

- prevention, detection, control and treatment of BBVs and STIs,
- active case finding/screening and vaccine preventable diseases, and
- outbreak prevention, detection and control (including disease surveillance systems).

It was also decided that TB among vulnerable groups, including people in prison, will be brought into the scope of this review.

## 2.2 Panels on substance misuse, mental health and prison inspection

The afternoon session was chaired by Dr Éamonn O'Moore and consisted of three panels.

The first panel was on substance misuse and the delegation heard from Dr Meykin Djunushova on substance misuse programmes in Kyrgyzstan, research on the role of methadone maintenance treatment in Eastern Europe and Central Asian countries by Lyuba Azbel, and a presentation on the prevention of overdose in deaths after release by Dr Ingrid Binswanger.

Dr Djunushova's presentation on substance misuse harm reduction programmes in Kyrgyzstan covered needle exchange programmes, opioid substitution treatment and a rehabilitation programme called 'Atlantis', which has been operating since 2007 for alcohol and drug dependent detainees and offers social and psychological support. These harm reduction measures are reflective of the drug use in Kyrgyzstan being mainly opioid based, and the programmes have had a positive impact on reducing drug use. Dr Djunushova reported that there were approximately 400 people registered in the opioid substitution treatment programme in prisons and the treatment programme has a 90% coverage of the prison estate in Kyrgyzstan.

Ms. Llyuba Azbel from the London School of Hygiene and Tropical Medicine, presented on her research in Eastern Europe and Central Asia on the role of methadone maintenance treatment in the prevention of deaths in custody and upon release from prison. Ms Azbel noted that Central Asian and eastern regions are the only areas where HIV is increasing, and that this is often associated with increased opioid use and incarceration. In her research on continuity of care from prison to community regarding drug treatment, only 27% of her sample were effectively linked to on-going support services post-prison release.

Ms Azbel also found environmental factors that influenced the uptake of methadone treatment to include social stigma around methadone users, a distrustful relationship between methadone users and prison officials, a drug trade inside the prison that challenges methadone use, and low doses being administered thwarting retention on treatment.

Dr Binswanger provided the final presentation in this panel and looked at deaths associated with drug overdose after release from prison. Her research showed that the first week after release presented a particularly high risk of drug overdose but not for non-substance misuse deaths. In these cases opioids were the predominant drug. A

history of panic disorder or mental health issues were linked to a higher risk of overdose on release, emphasising the effect of co-morbidity of drugs and mental health. There was some discussion about the naloxone programme in America and the developments of an intranasal product which has now been licensed in the country.

The second panel was on suicide, mental health and the prison environment and the delegation heard from the governor of Halden Prison in Norway, Mr. Are Høidal, and Mr Will Thurbin from the UN Office for Project Services on technical guidance on prison planning.

Mr Høidal presented his perspective on the development and running of Halden Prison as a different approach to prison design and management to improve wellbeing. In 2008, the Norwegian white paper: 'Punishment that works: less crime, safer society', advocated for more reintegration of people in prison into the community and for authorities to work together in partnership to achieve this. The white paper was presented by the ministers for Justice, Culture, Education and Local Government, reflecting the cross departmental approach to incarceration in Norway.

The normality principle is an important part of the basic values of correctional services in Norway; both in international conventions/recommendations and in Norwegian law, it is stipulated that inmates have the same rights as other citizens. The punishment is the restriction of liberty; no other rights have been removed by the sentencing court and therefore the sentenced offender has all the same rights as all other citizens of Norway. Other aspects of the approach in Norway include the fact that no-one shall serve their sentence under stricter circumstances than necessary for the security of the community, therefore offenders shall be placed in the lowest possible security regime. Importantly, during the serving of a sentence, life inside should resemble that seen outside the prison walls as much as possible. Part of working towards this sense of normality is that Correctional Services in Norway are expected to 'import' services from the community into the prison environment.

Mr Høidal went on to speak of the physical environment of Halden Prison, the facilities and operations of which reflect the principles and ambitions of the correctional services in Norway. Halden Prison is the newest and the most modern prison in Norway and is designed to be experienced by both inmates and staff in a friendly, non-authoritarian manner. The emphasis is on good relationships, good design, quality of materials and the investment in the physical space being as important to the wellbeing of those people in prison as well as those working in the prison.

Furthermore, the investment in prison staff training was particularly notable in this example from Norway. Prison officers are required to go through a two-year education at a staff academy, where they receive full pay and are taught a variety of subjects such as psychology, criminology, law, human rights and ethics. There is an emphasis on the

prison officer having a dual role of security staff and social worker. The prison workforce is 40% female.

This approach is associated with low levels of aggression and violence, both between prisoners and towards staff. Mr Høidal pointed out that this effect is difficult to filter out from the impact of the environment or the relatively high level of activity compared to other countries (in terms of work, education, cognitive programmes, training, etc), or a combination of these elements. Mr Høidal cited an independent Nordic study published in 2010 showed that the number of people who were released from a Norwegian prison and reoffended within two years was at 20%. Further work is required to understand the full impact of the Norwegian model at Halden Prison.

Mr. Will Thurbin from UN Office for Project Services presented on the ‘Technical guidance for prison planning’, published in 2016, and can be found here: [https://www.unops.org/SiteCollectionDocuments/Publications/TechnicalGuidance\\_PrisonPlanning.pdf](https://www.unops.org/SiteCollectionDocuments/Publications/TechnicalGuidance_PrisonPlanning.pdf). The guidance provides technical and operational considerations based on the Standard Minimum Rules for the Treatment of Prisoners (available here: [http://www.unodc.org/pdf/criminal\\_justice/UN\\_Standard\\_Minimum\\_Rules\\_for\\_the\\_Treatment\\_of\\_Prisoners.pdf](http://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf)) which in themselves do not set out how a prison ought to be built.

The guidance states that the function of a prison is to protect society from offenders who cannot serve their sentence within the community due to the severity or nature of their crime, to carry out the sentence imposed by a recognised legal process and to provide a safe and decent regime to help rehabilitate offenders so that they can lead useful and purposeful lives while in prison and upon release. The guidance takes a human rights approach to prison infrastructure and was developed in consultation with Penal Reform International, UN Office for Drugs and Drug-related Crime (UNODC) and the International Committee of the Red Cross.

The guidance recognises that there needs to be an understanding of how operations in a prison take place, such as delivering healthcare and coordinating family visits. Mr Thurbin also acknowledged Mr Høidal’s presentation in regards to the normality principle and believed that this was reflected in the guidance.

Mr Thurbin also raised the issue of how under resourced countries could draw on international new thinking around prison design. He noted that it was often not the building that is the most important thing but a focus on relationships and staff development. This UN guidance gives the opportunity for Public Health to contribute to prison design for wellbeing as well as immediate lifesaving technical advice on reducing opportunities for ligature points.



The third and final panel of the conference was on prison inspection and its role in preventing deaths in custody, with presentations from Judge Michael Reilly, Chief Inspector of Prisons in Ireland, Dr Marzena Ksel, Vice President of the European Committee for the Prevention of Torture and Ms Anne-Sophie Bonnet from the independent public body, Contrôleur Général des Lieux de privation de Liberté (CGLPL) in France.

Judge Michael Reilly opened this panel with his perspective as a senior member of the judiciary in the Republic of Ireland for over 30 years and then latterly as the Chief Inspector of Prisons in Ireland. He reminded the delegation that inspections of prisons may not actually prevent deaths but they can, by pointing to deficiencies in prison systems, try to ensure that the duty of care afforded to prisoners meets those obligations imposed on prisons by domestic laws and regulations, and more particularly by international treaties and international courts such as the European Court of Human Rights. He outlined his approach to prison inspections, the importance of independence, including the ability to criticise both prison and government policy when relevant. Judge Reilly noted that the findings and recommendations made by a robust and independent prisons inspectorate, if acted on, had the obvious potential to create a prison environment where the likelihood of prison deaths is reduced.

Dr Ksel's presentation spoke to the work of the European Committee for the Prevention of Torture (CPT) and highlighted that deaths in prison are one of the most important indicators of quality of care and as well as other system issues. The role of the CPT in inspecting prisons is to bring attention to cases, rather than to condemn authorities, and highlight process issues that could be improved upon. Dr Ksel went on to describe some of the cases of deaths in custody that had been brought to CPT's attention in the European Region to remind the delegation of the individual lives involved in the figures that the conference were focussing on.

Ms Bonnet described the work of her organisation, an independent public body in France to meet the Optional Protocol to the Convention against Torture (OPCAT) mandate by the UN Office for Human Rights:

<http://www.ohchr.org/EN/HRBodies/OPCAT/Pages/OPCATIndex.aspx>. The Contrôleur Général des Lieux de privation de Liberté (CGLPL) has made 150 visits to detained settings in France with a team of both health and justice professionals making independent inspections and recommendations to the French government.

Ms Bonnet raised the issue of overcrowding and its impact on accessing services, as well as the geographic location of prisons in relation to community facilities such as

hospitals. Training needs for healthcare professionals working in prisons was also noted so that they could take into account the prison environment.

The policy priority in France is to prevent suicide but Ms Bonnet presented principally on the French approach to thinking about whether the person could be restored as an active actor in their own lives. Suicide prevention measures such as fire resistant and tear resistant clothes were used to prevent suicides, but Ms Bonnet also suggested that we must be aware that this could increase the anxiety of prisoners due to these measures often making unfriendly and uncomfortable environments to live in. We must also be alert to these measures giving a false sense of security and that individuals were managed appropriately according to need.

The discussion after these panels raised the issue of whether a culture change to perceptions of incarceration was required to implement some of the good practice discussed at the conference or whether a reminder of what a fundamentally safe and decent prison regime looks like was all that was needed.

### WEPHREN reception

Following the conference a reception was held in honour of the WHO European Prison Health Research and Engagement Network (WEPHREN). The network is hosted by PHE and supported by Dr Emma Plugge from the University of Oxford. WEPHREN provides a forum for all stakeholders interested in prison health across the European Region to exchange ideas and to work together, with the potential to create collaborative multi-centre research proposals across the Region. Dr Éamonn O'Moore and Dr Emma Plugge asked delegates to complete a survey on research priorities and invited delegates to an informal reception in the UN City to celebrate the inception of WEPHREN.

## 3. WHO Europe regional consultation meeting

The aim of the regional consultation is to provide a platform for information exchange between the Regional Office and its network members. The meeting included presentations and discussions on specific initiatives in the area of prison health and prison health research related to the theme of Deaths in Custody.

The meeting was chaired by Mr. Stefan Enggist from the Federal Department of Home Affairs, Public Health and Communicable Diseases in Switzerland. Dr. Éamonn O'Moore from PHE represented the United Kingdom as the nominated government-delegate. A brief summary of the meeting is presented below.

### 3.1 Presentations

#### Suicide, premature mortality and serious reoffending in released prisoners

Professor Seena Fazel, University of Oxford

Professor Fazel presented on his work with Sweden on tracking people in prison into the community after release and mortality outcomes for this group. Suicide has been on the increase in the general population, however this study suggests that there was no clear association between suicide in the general population and in prisons; the idea that suicide in prisons was 'imported' from the community setting does not hold true. The study also suggests that the risk of death from substance misuse continues for many years, supplementing the work of Dr Binswanger on the first week after prison release being vitally important for support, but that for those misusing substances, the risks of premature mortality can continue for at least 10 years. The study also examined the impact of mental health indicators but this did not demonstrate such a clear relationship in the data as it was for substance misuse and comorbid substance misuse in these mental health cases may explain some of the association.

Professor Fazel also presented a unique sibling study looking at substance misuse and premature mortality after release from prison. The associations did not change from the reported findings above, suggesting a causative effect of substance misuse on premature death after prison release rather than just as an associated factor.

Professor Fazel reminded the delegation of the limitations of international comparisons between prison data, with different countries defining their data fields differently. His observations of conducting international research in this field are that there is little differentiation in regard to reoffending rates across high income countries. There was



evidence however of psychiatric disorders being associated with reoffending and he presented research that showed reoffending by psychiatric disorder and over time, which suggested a causal relationship between mental health and reoffending due to the increasing number of comorbid mental issues being associated with an increasing reoffending rate.

## WHO Minimum Public Health Dataset for Prisons

Dr Lars Møller, WHO HIPP

Dr Møller presented on the survey which has been disseminated to country focal points to build the WHO Minimum Public Health Dataset for Prisons that will be hosted by the Global Health Observatory at WHO Geneva. Dr Møller explained that there is a lack of comprehensive, consistent and reliable public health data on prison populations and their health needs across the WHO European Region. Where data are available currently, they show a higher prevalence of infectious disease, chronic illness and hazardous behaviour including injecting drug use among people in prison compared to peers in the wider community. The lack of a common minimum public health dataset limits ability to evaluate the quality of care provided in prisons and understand how this varies between member states.

WHO HIPP and the UKCC launched a Minimum Public Health Dataset for Prisons in Europe at the 2015 international conference in Kyrgyzstan, which will enable formal collection of data on agreed indicators and metrics at national level consistently across the WHO European region for the first time, supporting the development of robust prison health governance.

The database will be compiled from data reported at national level only. It will be collected via an online survey tool completed by a nominated key informant within the government ministry responsible for the health of prisoners (Ministry of Health or Ministry of Justice/Interior depending on jurisdiction) and delegates who had been nominated in this role were encouraged to complete and return the survey as soon as possible. If necessary, parts of the survey may need to be completed by other national experts nominated by the key informant.

The UKCC has supported the WHO HIPP and its member states to consider the challenges and opportunities in providing this information by performing a beta-test of the online survey tool and to gather data on a UK basis. A beta-test was also conducted by Portugal.

Dr Møller hopes to be able to report progress on this workstream at the next WHO Regional Consultation Event.

## WHO Europe Prison Health Research and Engagement Network

Dr Emma Plugge, WHO HIPP UKCC, University of Oxford

Dr Plugge described how the main focus of WEPHREN was fundamentally about improving the health of those in prison and the quality of the healthcare they receive. She emphasised that WEPHREN is not just for researchers but for everyone with a stake in the health of prisoners - policy makers, prison services, international organisations, public health organisations, healthcare staff and, of course, the people in prison themselves. Thanks to funding from PHE, WEPHREN had become a reality and work was underway on the 10 agreed priorities for Year One. An international steering group responsible for the oversight of its development had been established. Work was beginning on the production of a WEPHREN web platform linked to the WHO HIPP website. This was going to be very important for this 'virtual' network. Preliminary mapping of health research activity across the European Region showed that most output since 2000 came from the UK. There had been no research published from several countries. It is intended that the WEPHREN network will inspire and support prison health research from a wider variety of countries, thus fostering a more inclusive and representative evidence base.

As part of the engagement work with stakeholders, about 400 emails have been sent to individual stakeholders inviting them to join WEPHREN and seeking expert opinion on what key research priorities should be for the network. Initial responses from researchers across the WHO European region suggest that ageing, infectious diseases, health promotion, mental health, quality of care/professional standards, substance use and the health of women are research priorities. Emerging professional development priorities include training in both quantitative and qualitative research methods, on securing research funding and on involving users.

Some of the key areas the WEPHREN team will be working on in the coming months are the development of the website, further analysis of the research publications & priorities, and the development of specific international projects. Dr Plugge emphasised that it was now important for everyone to consider joining WEPHREN and to put forward their research and professional development priorities. She urged all those present to spread the word and to inform all those in their own networks about WEPHREN – all those with a stake in the health of prisoners are welcome to join and shape the development of this exciting new initiative. More information about WEPHREN can be found here: <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2016/10/new-network-launched-to-improve-research-in-prison-health>

### 3.2 Country/organisational updates on deaths in custody

The consultation meeting continued with an update from member state delegates regarding deaths in custody in their respective countries.

Dr Bobby Cohen from the New York City Board of Correction, United States of America, addressed the delegation on his work around reviewing deaths in custody and the impact of HIV prevalence in American prisons on the review process. He reminded us of the person behind the numbers and cited some individual cases of deaths in custody that were avoidable and resulted from poor management and care.

Dr Olivier Sannier from France introduced a new policy in France about compassionate release and suspension of sentence, which will be available from January 2017.

Dr Lesley Graham from Scotland presented on opioid related deaths in prisons and on release and the positive impact of a naloxone programme. Of 5.3 million Scottish people, approximately 60,000 have serious drug problems, resulting in disproportionately larger proportions of drug-related deaths. Over the last four years however the prison population has been slowly declining. Men in prison have a three times higher chance of dying as compared with the general population. Dr Graham also reported gender differences in terms of mortality; men have a four times higher chance and women a 19 times higher chance of dying as compared with the general population. Also, recently released prisoners have a higher risk of drug-related deaths. Dr Graham outlined the different interventions that have been implemented: from opiate substitution treatment, to an overdose awareness campaign to the provision of naloxone at point of release.

Dr Éamonn O'Moore presented statistics on the increasing deaths in prison custody across the four nations of the United Kingdom, including natural cause deaths and self-inflicted deaths. He also reported on the increasing levels of report violence, including self-harm and assaults on both prisoners and staff. Positive interventions to address these issues were highlighted including cross government departmental working groups as well as front line programmes such as peer support and increased mental health support. Dr O'Moore also mentioned the Prison Reforms in England and Wales, citing the published white paper to be found at:

<https://www.gov.uk/government/publications/prison-safety-and-reform> which includes health at its heart, a testament to the influence of the WHO "Good governance for prison health in the 21<sup>st</sup> century. A policy brief on the organization of prison health".

<http://www.euro.who.int/en/publications/abstracts/good-governance-for-prison-health-in-the-21st-century.-a-policy-brief-on-the-organization-of-prison-health-2013>

Brenda van den Bergh reported on the work of her organisation DIGNITY, a Danish human rights institute which works with treatment, research, international development

work and advocacy <https://www.dignityinstitute.org/>. The organisation is represented in more than 20 countries where they cooperate with local partner organisations to fight torture and help torture victims and their families to a better life. Their role in deaths in custody is to focus on monitoring and reporting of these deaths.

Alison Hannah from Penal Reform International presented on their work in Africa <https://www.penalreform.org/>. Penal Reform International is an independent body that has over 20 years' experience working in the field of criminal justice and penal reform at national, regional and international levels.

Conditions in African prisons are some of the poorest in the world lacking sanitation and access to proper medical care. Few of these prisons provide rehabilitative programmes, educational or vocational opportunities. There is a high rate of pre-trial detention and the overuse of prison sentences for minor offences contributing to severe overcrowding, with many prisons holding up to twice their official capacity. Ms Hannah echoed some of the comments from previous speakers about the importance of dignity and respect in developing the idea of equivalence of care in resource poor countries.

Jan Malinowski from the Pompidou Group of the Council of Europe presented on the importance of human rights for those using substances and posed the idea that depriving someone of opiate substitution treatment (OST) amounted to poor care and contravened human rights, as a lack of OST could increase the risk of death in some cases. He spoke of a study on drug treatment systems in Eastern and South-Eastern countries that the Pompidou Group were working on which was to be published yet and that essentially the principle of assessing health needs and providing care accordingly constituted providing equivalent care in prison compared to the community.

Dr Carole Dromer from the International Committee of the Red Cross described the visits the ICRC does in their inspection role and the ICRC's 2013 guidelines on inspecting prisons <https://www.icrc.org/en/publication/4126-guidelines-investigating-deaths-custody>. Dr Dromer highlighted that she had observed that a consideration of medical ethics were often missing when ICRC visited some countries. Changes to systems took many years to achieve, with the impact of ICRC visits taking time to filter through to changes in practice. ICRC is interested in looking at the impact of solitary confinement in developed countries in the future. ICRC also recognised the importance of a WHO Health in Prisons Programme and called for other WHO regions to consider their work on health and justice.

### 3.3 Closing remarks on the regional consultation event

The meeting was closed by Dr Hans Kluge, Director of the Division of Health Systems and Public Health, and Special Representative of the Regional Director to prevent and combat multi-drug resistant TB (M/XDR-TB) in the WHO European Region. He

remarked on his experiences of tuberculosis in prisons and the huge responsibility of working in prisons; prisons could either be used as a public health opportunity or left to be a setting of some of the poorest health outcomes. Dr Kluge acknowledged that the harsh setting of a prison can also impact on the staff working there and shared some of his own experiences. He commended the attempts of intersectoral working in prison health and supported the need for increased efforts from organisations such as WHO to focus on prison health due to the social vulnerability of people in prison. Prison health is core to the WHO mandate and the UN's Sustainable Development Goals of 'leaving no-one behind'.

## 4. Conclusions



Deaths in custody remain a challenge for health and justice colleagues, however, there was an inspiring and motivational message from the conference and regional meeting about using a whole prison approach to address the underlying factors that contribute to deaths in custody, and the work that needs to be done to change perceptions of people of prison in order to deliver interventions and improve wellbeing.

PHE were able to showcase many of the innovative health and justice activities in England: Physical Healthchecks in Prisons, implementation of a BBV opt-out programme, reviewing the impact of prison healthcare under the Department of Health, working with NICE to develop guidelines on physical health of people in prison and the upcoming mental health guidelines, and the approach being taken in prison reforms to consider the prison as a whole system and its links with the local community. PHE has built on its global reputation in excellence in health and justice, bringing the local experience in the UK to an international stage.

The UK collaborating centre to the WHO HIPP is an example of PHE's role in strengthening UK partnerships for global activity. Its leadership role in shaping the international health and justice agenda is widely acknowledged and this conference has given PHE an opportunity to develop its international ambitions on research, and communicable and non-communicable disease prevention in order to reduce health inequalities and improve health in the justice system and wider community.

## 5. Useful documents and links

International Committee of the Red Cross (2016). Guidelines for investigating deaths in custody.

<https://www.icrc.org/en/publication/4126-guidelines-investigating-deaths-custody>

Public Health England (2014). Global health strategy 2014-2019.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/354156/Global\\_Health\\_Strategy\\_final\\_version\\_for\\_publication\\_12\\_09\\_14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/354156/Global_Health_Strategy_final_version_for_publication_12_09_14.pdf)

UN. Standard minimum rules for the treatment of prisoners.

[http://www.unodc.org/pdf/criminal\\_justice/UN\\_Standard\\_Minimum\\_Rules\\_for\\_the\\_Treatment\\_of\\_Prisoners.pdf](http://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf)

UNOPS (2016). Technical guidance for prison planning.

[https://www.unops.org/SiteCollectionDocuments/Publications/TechnicalGuidance\\_PrisonPlanning.pdf](https://www.unops.org/SiteCollectionDocuments/Publications/TechnicalGuidance_PrisonPlanning.pdf)

WHO Health 2020 strategy

<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020>

WHO (2013). Good Governance for Prison Healthcare in the 21<sup>st</sup> Century

<http://www.euro.who.int/en/publications/abstracts/good-governance-for-prison-health-in-the-21st-century.-a-policy-brief-on-the-organization-of-prison-health-2013>

WHO European Prison Health Research and Engagement Network (WEPHREN)

<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2016/10/new-network-launched-to-improve-research-in-prison-health>

WHO Minimum Public Health Dataset for Prisons

<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2015/06/health-in-prisons-programme-steering-group-sets-agenda-for-20152016>

# Appendix 1

## Agenda for the conference and regional consultation event

WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION  
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ  
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ  
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО



**WHO regional consultation  
on prisons and health  
Copenhagen, Denmark  
3–4 November 2016  
Auditorium III**

**27 October 2016**

**Original: English**

### Provisional programme

#### **WHO regional consultation on prisons and health in joint collaboration with Public Health England (PHE)**

**Theme: Deaths in custody**

#### **Thursday, 3 November 2016**

|                         |   |
|-------------------------|---|
| 08:15–09:00             | Registration of delegates   |
| 09:00–09:30             | Welcome by <b>Dr Gauden Galea</b> , Director Division of Noncommunicable Diseases and Promoting Health through the Life-Course, WHO Regional Office for Europe                  |
| 09:30–10:00             | Danish Prison and Probation Service – Overview of the Danish prison health care system, <b>Mrs Lise Nordskov Nielsen</b> , Head of Section, Danish Prison and Probation Service |
| <b>Morning session:</b> | Presentations on natural cause mortality, noncommunicable diseases and tuberculosis   |



- Chair:** **Dr Lars Moller**, Programme Manager, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe
- 10:00–10:30 Keynote presentation: Death in custody, **Dr Ingrid Binswanger**, Senior Investigator, Kaiser Permanente Colorado, Associate Professor, University of Colorado School of Medicine
- 10:30–10:40 Question & Answer session
- 10:40–11:10 Noncommunicable Diseases, **Dr Emma Plugge**, University of Oxford and **Dr Ruth Elwood Martin**, University of British Columbia, Canada
- 11:10–11:20 Question & Answer session
- 11:20–11:45 Coffee/tea and poster viewing in Atrium (Finger 9)  
11:45–12:05 Cardiovascular Disease prevention and Physical Health checks in English prisons, **Dr Jo Peden**, Public Health England, United Kingdom
- 12:05–12:15 Question & Answer session
- 12:15–12:30 Communicable disease: Presentation by **Dr Famil Mammadov**, WHO Collaborating Centre on prevention and control of tuberculosis in Prisons, Azerbaijan
- 12:30–12:45 Question & Answer session
- 12:45–13:45 Lunch and poster viewing in Atrium (Finger 9)
- Afternoon session:** Panel 1: Discussions on substance misuse, self-inflicted deaths and the prison environment, prison inspection
- Chair:** **Dr Éamonn O'Moore**. Director UK Collaborating Centre, WHO Health in Prisons Programme
- 14:30–15:05 **Panel 1: Substance misuse**
- Dr Meykin Djunushova** on substance misuse in prisons in Central Asia/Kyrgyzstan
- Ms Lyuba Azbel**, the role of methadone maintenance treatment in the prevention of death in custody and upon release from prison, for Eastern Europe and Central Asian countries, London School of Hygiene and Tropical Medicine
- Dr Ingrid Binswanger**, prevention of overdose deaths in and shortly after release

- 15:05–15:15 Question & Answer session
- 15:15–15:35 Coffee/tea in Atrium (Finger 9)
- 15:35–16:05 **Panel 2: Suicide, mental health and the prison environment**
- Mr Are Høidal**, Governor of Halden Prison, Norway. A different approach to prison design and management to improve wellbeing
- Mr Will Thurbin**, Correctional expert and co-author of the Technical Guidance document, UNOPS
- 16:05–16:15 Question & Answer session
- 16:15–17:00 **Panel 3: Prison inspection and its role in preventing deaths in custody**
- Judge Michael Reilly**, Inspector of Prisons, Ireland
- Dr Marzena Ksel**, Vice President of European Committee for the Prevention of Torture (CPT)
- Ms Anne-Sophie Bonnet**, Controller, in charge of international relations, Independent Public Body, France
- 17:00–17:15 Question & Answer session
- 17:15–17:30 Summing up
- 17:30–17:45 WEPHREN launch
- 18:00–19:30 Reception in Atrium (Finger 9)

**Friday, 4 November 2016**

- 09:00–09:05 Introduction by Chair – **Mr Stefan Enggist**, Federal Department of Home Affairs, Federal Office of Public Health, Department of Communicable Diseases, Switzerland
- 09:05–09:50 Keynote: **Professor Seena Fazel**, University of Oxford on Suicide, premature mortality, and serious reoffending in released prisoners – the links with mental illness and substance *misuse*
- 09:50–10:05 *WHO Minimum Public Health Dataset for Prisons* – **Dr Lars Moller**, Programme Manager, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe
- 10:05–10:25 WHO Europe Prison Health Research and Engagement Network (WEPHREN) – **Dr Emma Plugge**, UK Collaborating Centre for the WHO Health in Prisons Programme

|             |  |
|-------------|--|
| 10:25–10:55 | Coffee/tea in Atrium (Finger 9)  |
| 10:55–13:15 | Country/organizations update with focus on the theme of deaths in custody (10 -15 minutes)<br><br><b>Dr Bobby Cohen, US</b><br><b>Dr Olivier Sannier, France</b><br><b>Dr Éamonn O'Moore, UK</b><br><b>Ms Brenda van den Bergh, DIGNITY</b><br><b>Ms Alison Hannah, Penal Reform International</b><br><b>Mr Jan Malinowski, Pompidou Group of Council of Europe</b><br><b>Dr Lesley Graham, ISD, National Services Scotland</b><br><b>Dr Carole Dromer, International Committee of the Red Cross</b> |
| 13:30–13:35 | WHO HIPP Regional Consultation 2017  |
| 13:45–14:00 | Summing up and close   |
| 14:00       | Lunch in Atrium (Finger 9) and departure   |