

The Sexual Health and Behaviour of Male Prisoners: The Need for Research

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Abstract: Sexually transmitted infections (STIs) are a major public health problem in the United Kingdom (UK) and the limited data available may suggest high prevalence rates (especially of HIV, hepatitis B and C) in the escalating male prison population. Sex, rape and injecting drug use are a part of prison life, yet screening for STIs does not routinely take place and there are inconsistencies in the availability of condoms and other harm-reduction devices. Numerous characteristics of male prisoners (for example, social disadvantage, drug dependency, younger age, black ethnic origin, on remand), their offences (drug, sex, violent) and overcrowded prisons (for example, sharing cells, staff shortages, enforced idleness, transfers) are also considered 'high risk' from a sexual health perspective, especially the spread of STIs between prisoners and into the wider population when they are released. There is, therefore, an urgent need for research so that sexual health information and HIV/STI prevention initiatives can be successfully targeted.

Sexually transmitted infections (STIs) are a major public health problem in the United Kingdom (UK), and their escalating prevalence rates are largely the result of unprotected sex and, to some extent, sharing contaminated needles. It is acknowledged that consensual and non-consensual sex and drug abuse are part of prison life, and the limited data available show that prisoners have high prevalence rates of STIs, especially human immunodeficiency virus (HIV), hepatitis B and C, which can be brought into prison, acquired there and, if undetected and untreated, spread into the wider population when prisoners are released (HM Prison Service 1999, 2001; Yirrell *et al.* 1997; Chalmers 2002). STIs, however, are not the only sexual health-related problems experienced by prisoners. It is estimated that approximately 10,000 of the 200,000 prisoners who pass through the prison system annually may have been coerced sexually (Banbury 2004). Symptoms of the psychological problems resulting from sexual assault are similar to those of post-traumatic stress disorder, for example, intrusive thoughts, flashbacks, anxiety, avoidance behaviour, depression (Matthews *et al.* 2000), and these may be particularly difficult to deal with in the prison environment, continue when prisoners are released, and may play a part in reoffending.

England and Wales has one of the highest imprisonment rates in the European Union at 141 per 100,000 (52% higher than France, its nearest neighbour) and its prison population has increased by approximately 40% in the last ten years – as at 30 September 2005, it was 77,291 (Howard League for Penal Reform 2005). The sexual behaviour and health of prisoners, however, has been neither a policy nor research priority. The national strategy for sexual health and HIV (Department of Health 2001) only mentioned prison sexual health once: ‘targeted sexual health information and HIV/STI prevention’ for ‘people in prisons and youth offending establishments’ (p.20), and sexual health is not a specific category in *The Prison Health Handbook* (Narey, Crisp and Lloyd 2003). Prisoners, like the homeless, are missed in most population samples, and a mapping exercise of sexual health-related research in the UK, which aimed to highlight current trends and gaps, identified only one study of prisoners, out of a total of 346 projects found (Stewart and Pryce 2004).

The sexual health and behaviour of male prisoners is of particular concern because the escalating prison population is predominantly male – 94% in England and Wales, where only 14 of 138 prisons are female (Prison Reform Trust 2003). This article aims to highlight the characteristics of male prisoners, their offences, behaviour and the prison environment, which are known or can be assumed to constitute ‘risk’ from a sexual health perspective, especially the acquisition of STIs, in order to emphasise the need for research. It begins by briefly describing the general health of the prison population and summarising what little is known about the sexual health of male prisoners.

The Health of the Prison Population

Socio-economic factors play a huge part in health and there is a link, albeit complex, between poor health and crime (British Medical Association 2004). In the chaotic lifestyles of many prisoners, health has been a low priority – they often smoke and drink heavily, and it is estimated that 50% have no GP before entering custody. The most common conditions in prisoners are diabetes, asthma, communicable diseases (which includes STIs), drug addiction (which can increase the risk of STIs), and mental illness (HM Prison Service 2002; Dale and Woods 2002). Many have suffered a lifetime of social disadvantage and exclusion,¹ which are particular risk factors for poor sexual health (Social Exclusion Unit 2003), as well as homelessness and tuberculosis (TB). Also, people with HIV are much more vulnerable to TB (contracting and progression), which is of increasing concern in UK prisons – in the United States (US), outbreaks of TB have occurred among prisoners and staff where there are large numbers of HIV+ inmates (HM Prison Service 1999).

The Prison Health Handbook (Narey, Crisp and Lloyd 2003) states that prisoners should receive care equivalent to National Health Service (NHS) standards; however, the changing availability and variation in quality of health care provided by the Prison Medical Services has been acknowledged in official reports (HM Prison Service 2001/2; Narey, McKay and

Gregory 2000; Narey, Crisp and Lloyd 2003). According to the British Medical Association (2004), some prison administrators have not co-operated with health care staff and some governors have actively opposed the clinical judgment of doctors. Health services for prisoners are gradually being transferred to the NHS – all Primary Care Trusts (PCTs) in England should have frontline responsibility for the health of those detained in prisons in their area by April 2006. The focus of current sexual health initiatives is HIV, hepatitis B and C (Department of Health 2004), reflecting an acknowledgement of the serious drug problem among prisoners, especially those who come from and will return to deprived communities (British Medical Association 2004).

The Sexual Health of Male Prisoners

It is increasingly being recognised that there are high prevalence rates of STIs (especially blood-borne viruses) in the male prison population – a study in eight prisons in England and Wales found the following rates in the total prison population sampled: 0.4% – HIV; 8% – hepatitis B; and 7% – hepatitis C (HM Prison Service 2001). In the general population the rates are much lower: 0.007%, 0.3% and 0.4%, respectively (Public Health Laboratory Service 2001a). Past and current injecting drug users are at increased risk – the afore-mentioned study found a prevalence rate of 20% for hepatitis B and 30% for hepatitis C among the prison population who had ever injected (HM Prison Service 2001).

During the outbreak of HIV at Glenochil Prison in Scotland, 10% of the 169 prisoners tested were HIV positive and transmission between prisoners was detected – clinical history and sequencing similarities in 13 of 14 HIV+ men demonstrated a common index case (Yirrell *et al.* 1997). In 1999, the Health Education Authority acknowledged that prison is potentially a high-risk environment for the spread of HIV (Health Education Authority 1999). This was confirmed in February 2001, by a high-profile case in Glasgow – under Scottish law, Stephen Kelly was convicted of recklessly injuring his former girlfriend by infecting her with HIV which, it transpired, he had acquired as a result of intravenous drug use while serving a prison sentence (Chalmers 2002).

According to the Social Exclusion Unit (2003), prisoners are 15 times as likely as the general population to be HIV positive. The vulnerability of prisoners to HIV and other STIs was shown by a recent study of 291 male prisoners (80% aged less than 35 years) attending an STI clinic in a large English prison over 18 months – 54% required treatment for STIs (some for more than one), 39% had an HIV test and 14% were vaccinated for hepatitis B. Interviews with 20 prisoners revealed that, prior to coming to prison, 60% had attended an STI clinic, 40% had had an STI, and 70% had previously taken an HIV test. Also, some health care professionals had proof that STIs (HIV and hepatitis C) were being transmitted in prison; and the fact that 19 prisoners had been in other prisons and that nine had been in five or more prisons highlighted the possibility of the transfer of infection between prisons (Roberts 2003),

as well as into the community on release. Prison population statistics show that a large proportion of male prisoners aged 21 to 39 years are 'pleasure seekers' and, since they are more likely than the outside population to have injected drugs, had multiple female sexual partners, and sex with men, it is understandable that they might want to celebrate release from the confines and frustration of a prison sentence with a potentially risky combination of sex, drugs and alcohol (Ward 1996; Burrows 1995; Gore and Bird 1993).

Sexual health screening and treatment services are not consistently provided in prisons and, where they exist, are stretched to the limit. All prisoners must see a medical officer within 24 hours of being admitted; however, their sexual health is not routinely assessed at this time unless the prisoner identifies a problem. Also, many prisoners may be transferred or released before they are able to complete the six-month course required for hepatitis B vaccination (HM Prison Service 1999), attend the set days of a clinic for screening, test results or follow-up treatment, because they can only be moved if the custodial timetable allows (Roberts 2003).

Less than half of the young offender institutions (YOIs) in England and Wales have regular sexual health clinics run by genito-urinary medicine specialists (Tang 2003), despite the fact that approximately 15% of prisoners are under 21 years of age and the number aged under 18 years has doubled in the last ten years (Prison Reform Trust 2003, 2005). Numerous studies testify to the risky sexual behaviour of young people in the UK – seen in escalating prevalence rates of STIs and the number of unwanted teenage pregnancies (Teenage Pregnancy Unit 2001; Wellings *et al.* 2001; Public Health Laboratory Service 2001b), and the poor sexual health of young offenders, in particular, is increasingly being acknowledged – they have high rates of sexual partner change and acquisition of STIs during spells outside YOIs. It is estimated that 25% are fathers and 39% are mothers, and a survey of young offenders aged 15 to 16 years in Reading YOI found the incidence of STIs to be about 50%. They are more socially deprived and excluded than older prisoners and, consequently, at increased risk of poor sexual health (Social Exclusion Unit 1999; Teenage Pregnancy Unit 2001; Tang 2003; Social Exclusion Unit 2003).

The over-representation of prisoners from black and minority ethnic (BME) groups (Levy 1997), especially black groups, also makes the male prison population 'high risk' for poor sexual health – approximately 25% of prisoners are from BME groups, the largest proportion (15%) are from black groups, and their numbers are rising much more dramatically when compared with the total prisoner population (Prison Reform Trust 2003, 2005). This is because research shows that people of BME origin, especially black African and Caribbean, are more likely to have unprotected sex and multiple sexual partners (reflected in high prevalence rates of chlamydia, gonorrhoea and HIV in their communities in the UK) and that, despite the increase in heterosexual transmission of HIV, they are more reluctant to come forward for testing due to their experience and perception of the stigma attached to this STI (Hughes *et al.* 2000; Evans, Bond and MacRae 1998; Weatherburn *et al.* 2000; Fenton *et al.* 2002; Erwin *et al.* 2002).

Substance Addictions

Drug and alcohol use are risk factors for poor sexual health especially the acquisition of STIs – sex is more likely to be unprotected when drugs and alcohol are involved (Dupont *et al.* 2002), they are often incriminated in incidents of sexual abuse (Burke and Follingshad 1999), and sharing needles to inject drugs increases the risk of acquiring HIV, hepatitis B and C. Prisoners, especially male, are particularly vulnerable to these risk factors because they have higher than average rates of substance misuse problems (Mason, Birmingham and Grubin 1997) – approximately 75% have abused drugs in the 24 hours before arrest, two-thirds have used illegal drugs (especially heroin and crack cocaine) in the year before imprisonment, and 50% admit to hazardous drinking (Social Exclusion Unit 2003; HM Prison Service 2004). Drug and alcohol abuse is also a serious problem in young offenders – 66% of males aged 16 to 20 years have hazardous drinking habits, more than 50% report drug dependence, and nine out of ten have used drugs (Prison Reform Trust 2003; Hollis and Cross 2003).

As with substance abuse, prisoners have higher than average rates of mental illness (British Medical Association 2004), and many prisoners with substance addictions also have mental health problems, the so-called ‘dual diagnosis’ (HM Prison Service 2004). Although black prisoners are more likely to have mental health problems, they are less likely to have used illicit drugs (apart from cannabis) and injected (with the exception of crack cocaine) than white prisoners (Coid *et al.* 2002). Remand prisoners may be particularly vulnerable to both. Approximately one-sixth of the prison population are on remand (unconvicted awaiting trial or convicted but unsentenced) and their numbers are also increasing; more than 20% are both aged under 21 years and from BME groups; and, approximately 80% of men are charged with a non-violent offence. In 2002, 66% of more than 82,000 people remanded in custody were found innocent and, although the average time waiting for trial was 49 days for men, some spent more than twelve months on remand (Prison Reform Trust 2003, 2005; Hollis and Cross 2003).

A study of 750 male remand prisoners in England and Wales (Farrell *et al.* 2002) found that a third had substance misuse problems (10% were dependent on opiates, 11% on stimulants and 12% on alcohol), and they were also more likely to be socially disadvantaged and suffer from mental health-related problems. It was concluded, therefore, that drug or alcohol dependencies are a marker for vulnerability within this underprivileged population.

Drug Use and Treatment in Prison

Although 70% of those entering prison have a drug misuse problem, 80% have never had contact with drug treatment services. The prison service drug strategy has proved effective – the rate of positive mandatory drug tests halved between 1996 and 2003 (from 24.4% to 11.7%) and reconviction rates for those completing prison-based drug treatment

programmes dropped from 54% to 30%. However, some prisoners are excluded because one of the key criteria for these programmes is available sentence length – usually at least three months, with more intensive programmes being reserved for prisoners with histories of severe drug dependency and related offending with a minimum of 12 to 15 months left in prison (Social Exclusion Unit 2003; Home Office 2003; HM Prison Service 2004). Despite the escalating problem of drug addiction in young people, only one in three YOIs provide drug treatment programmes (Prison Reform Trust 2003).

Drug abuse in prison may occur because of the particular inability of vulnerable prisoners to cope with prison life, which is reflected in the large number of prisoners (10%) reporting sick every day – nearly eight times more than the general population who visit their GP daily (British Medical Association 2004). Thus, some people may become addicted to drugs in prison as a way of escaping the unbearable conditions or to ‘fit in’ with other prisoners, with serious consequences for their sexual health, as a prison health care professional in a recent study highlighted (Roberts 2003):

We have had guys who didn't do drugs before coming in and tested negative. In here, started with soft stuff and then onto injecting. (p.43)

Injecting equipment is prohibited in prisons, but surveys of ex-prisoners have shown that up to 17% shared syringes in custody (Burrows 1995). Procedures for staff to manage the risk of becoming injured and infected with HIV, hepatitis B and C by concealed injecting equipment while searching prisoners and prisons (HM Prison Service 1999) and the re-introduction of disinfecting tablets in prisons in England and Wales (HM Prison Service 2003a), further confirms that prisoners can acquire injecting equipment in prison and that needle-sharing is a reality. The provision of disinfecting tablets, however, is no guarantee that sharing ‘dirty needles’ will cease to occur – this is because the pressure to ‘get a hit’ inside may mean there is no time to clean equipment before passing it to prisoners in the same cell or block (Roberts 2003). Also, as shown by a study in four Dublin prisons (with high rates of blood-borne viral infections among prisoners), the majority of prison officers may not know enough about hepatitis B and C and HIV to enable them to take the necessary precautions, despite training (Dillon and Allwright 2005).

Drug use often continues or begins again on release, and the continued need for drugs may play an important part in homelessness and re-offending, and also serious consequences for the general and sexual health of ex-prisoners and the wider population. A study of ex-prisoners (mostly short-term) found that 77% had taken illegal drugs since release – 28% had used heroin (half at least daily). The mortality rate of ex-prisoners is three-and-a-half times that of the general population and accidents often involve drugs and alcohol – post-custody deaths usually occur within the first four weeks of release, suggesting a strong link with overdosing. Of prisoners released in 1997, 58% were convicted of another crime within two years; 18 to 20-year-olds were reconvicted at the much higher rate of 72% with approximately two-thirds receiving another prison sentence (Burrows

1995; Social Exclusion Unit 2003). Also, young people are increasingly selling sex to fund their drug habits (May, Edwards and Hough 1999).

Drug and Sex Offences

Drug offences are the third most common offence (after violence against the person and burglary) in men – 15% of all offences and the most common in black men. However, the Home Office (HO) estimates that a third of all theft-related crimes can be linked to heroin purchase (Home Office 2003). Although drug offences are only the sixth most common in young people, drugs may be implicated in more frequent crimes (motoring, theft and handling, violence against the person, criminal damage and public order), especially in young men (Youth Justice Board for England and Wales 2004). As already noted, drug addiction may be the motivation for many young sex workers, and they have high levels of sexual and drug risk behaviours and are vulnerable to abuse (May, Edwards and Hough 1999).

There is growing concern in the UK about the link between sex and drug markets, STIs, and violence. Many pimps are involved in drug dealing, have significant drug habits, and long (often violent) criminal histories; trafficking for sexual exploitation is also increasing and linked to drug markets and other forms of criminal activity (May, Edwards and Hough 1999; May, Harocopos and Hough 2000; Kelly and Regan 2000).

Prostitution and re-victimisation are only two of many problems associated with risky sexual behaviour with which childhood sexual abuse has been linked and, although sexual abuse of girls may be more prevalent, evidence from the United States suggests that boys who have been sexually abused engage in riskier sexual behaviour and also have greater difficulty controlling sexual feelings, are more likely to be hypersexual and perpetuate sexual acts against others, than un-abused boys (Pettrak, Byrne and Baker 2000; Greenberg 2001).

Men are overwhelmingly the main perpetrators of sexual abuse, assault and rape. The number of female rapes in the UK is escalating, although this may partly be due to increased reporting (Myhill and Allen 2002). Male rape has only been recognised since 1994, and Home Office statistics for 1997 show that 342 men were raped that year (compared to 5,759 women). However, it is suspected that only one in ten men report rape because of the 'myths' surrounding this crime: only gay men rape/are raped; it just affects the weak; and, it is only about sexual gratification when, as with female rape, it is often about power (Home Office 2003; BBC 2003).

In 2000, in England and Wales, the rate per 100,000 of the population for males found guilty or cautioned for sexual offences was 34 in 10 to 20-year-olds and 21 in those aged 21 years and over, compared to zero for females of all ages (Home Office 2000). As at April 2003, there were 5,484 men convicted of sexual offences, and 55% of the male prison population aged 60 years and over have committed sex offences. There is a significant number of older men in prison – in 2001, 3% of sentenced prisoners were aged 60 to 88 years, which may be due to the noticeable rise in the numbers

being given life sentences, and huge increase (88%) in men sentenced to four or more years, although the proportion given short sentences (less than one year) has doubled in the last ten years (Prison Reform Trust 2003, 2005; Hollis and Cross 2003).

Consensual Sex and Sexual Coercion in Prison

Numerous writers, including Erving Goffman, have commented on the inevitability of sex and rape in prisons and other 'total institutions' (Goffman 1968). In 1997, UNAID reported sexual contact between men in custody to vary from a high of 73% in Brazil to between 6% and 12% in the UK and Australia, although this was probably an underestimate because of reluctance to report (World Health Organisation 1997).

Little has been published about sexual activity in UK prisons, but it is an increasingly popular research topic in the US – a recent publication (Hensley 2000) which focuses on sex (consensual and non-consensual) in American prisons, highlights why it can never be eradicated. It shows how the hierarchy in male prisons is based almost entirely on gang status on the outside and sexual status on the inside – within this hierarchy, it is often the young, white, slightly built 'pretty boy' who becomes the sex slave to the older, black, more experienced prisoner. It also considers the effects of conjugal visits, HIV/AIDS management, how the phenomenon of situational homosexuality can impact on the rehabilitation of prisoners, and also how perceptions and attitudes to rape are constructed and, consequently, can be broken down. However, a report by Human Rights Watch in 2000 (Human Rights Watch 2000) (following three years of research involving 200 prisoners in 37 states), criticised the attitudes of prison staff to male rape, epitomised in the phrase 'you're gay so you must have enjoyed it'. As well as documenting the harrowing accounts of prisoner-on-prisoner sexual abuse, it also quoted statistics showing that, after suicide, HIV/AIDS-related illness is the main cause of death among American prisoners.

In England and Wales, there has been recognition of sexual activity in male prisons via consistent messages from the prison service that the supply and use of condoms is allowed – service orders and letters have regularly been issued by principal medical officers (HM Prison Service 2001/2). However, it is governors who have the management responsibility for the health of prisoners, and they may not allow the distribution of condoms. In the study involving health care professionals working with male prisoners in the UK, this, and also the need for condoms was acknowledged (Roberts 2003):

Men will have sex here, it's usually consensual, though they are not usually gay or bisexual. Heterosexuals still need to have sex whether they are incarcerated or not. They do have sex so let them do it safely with condoms.

We had an openly gay guy who was positive for HIV, Hep B and Hep C asking for condoms because he was worried about passing them on to others. We weren't allowed to give them to him, he is out there having sex and spreading them about the prison through unprotected sexual intercourse. (p.43)

One health care professional stated that the governors would not allow him to give out condoms in any of the three prisons he visited – two of the reasons given were that prisoners would use them to swallow packages or they may block drains. In some prisons, condoms were available only via prescription which meant explaining and legitimising why they were required, seeing a doctor, then waiting for the pharmacist to dispense and distribute them via medical or other prison staff. Since privacy cannot be guaranteed in this process, it was concluded that it is not surprising that prisoners are reluctant to request condoms (Roberts 2003).

The problem of rape in male prisons has been acknowledged (Roberts 2003; Taylor 2003). From the evidence available, the majority of victims are in prison for the first time, young, slightly built and suspected of being gay. There are many reasons for sexual violence: sexual gratification/power; repayment of a debt or payment for protection by a more experienced prisoner; and, punishment for a violation of prisoners' codes and rules. It can also take many forms, and the use of instruments, such as snooker cues, are not uncommon and de-sexualise the assault on the part of a perpetrator reluctant to be seen as gay. However, reporting sexual assault in prison has the same inherent problems as reporting other offences, and members of prison staff are not specifically trained to deal with sexual violence. Many prisoners may, therefore, suffer in silence because being labelled a 'grass' guarantees hostility or violence from other prisoners; and some may consider suicide to be the only option (Taylor 2003). A recent study of coercive sexual behaviour (sexual exploitation, rape and sexual assault including forced drug searches) in British prisons (Banbury 2004) confirmed this. It found that victims were reluctant to report incidents because of: fear (of repeat incidents, drug abstinence, disciplinary action, loss of parole); shame; staff reluctance to acknowledge existence of sexual relationships; and, lack of confidential psychological/medical interventions for victims and perpetrators.

This study involved 408 adult ex-prisoners, of whom approximately 80% were in the following categories: male; white; heterosexual; and, under age 33 years. It found that 1% had been sexually coerced involving sexual intimacy and 4% had been subjected to forced drug searches. Victims were predominantly younger, passive, and without group affiliations; victims of sexually intimate incidents were also homosexual and inexperienced; those who had been searched forcibly were also drug dependent. Perpetrators were predominantly prisoners rather than staff and approximately 50% of incidents involved more than one perpetrator – in half of these there were multiple perpetrators. The severity of injuries depended on frequency of incidents, number of perpetrators, degree of force, whether a weapon was involved or condoms/lubricant used, although safer sex materials to protect against STIs were very rarely used and some injuries, for example, anal bleeding and cuts, could increase the risk of their spread. The psychological problems following an incident were also considerable for almost all victims – depression, shame, guilt, anxiety, nightmares, exacerbated drug use, suicide attempts, self-harm, anger, rage and aggression (Banbury 2004).

The majority of incidents occurred in prison cells (usually involving cellmates), in the evening or during the night, especially following visits, and in the early stages of incarceration, when aggressive behaviour, drug-related problems, psychological and other effects of initial institutionalisation may be pronounced. Although members of ethnic groups experienced racial abuse in prison and harassment during drug and strip searches, they were infrequently reported to be involved in sexual incidents (Banbury 2004).

Banbury identified a cycle of sexual victimisation in which different types of exploitative relationships exist – sexual intimacy may be coerced by a dispenser of gifts, in return for a favour and can include blackmail, violence, and sex in exchange for goods. Victims may remain with the initial perpetrator or be pimped out, be intimidated not to report incidents and suffer physical and psychological trauma, which increases their vulnerability. The perception that coercive sexual activities are consensual, or discreet and isolated, helps to camouflage incidents.

Banbury also highlights how coercive sex in prison exacerbates any pre-existing levels of trauma because the victim cannot escape from the perpetrator and the level of psychological dysfunction (rape trauma syndrome) may become so intensified that the effects may continue on release and perpetuate offending behaviour. If STIs are the physiological consequences, then public health may also be damaged. Numerous factors contributed to incidents of sexual coercion: absence of sexual/fulfilling relationships and conjugal visits; homophobia; psychological dysfunction; inability to fully exercise legal rights; inadequate staff and prisoner awareness; and, overcrowded autocratic prisons (Banbury 2004). This highlights the importance of the prison environment, especially the negative effect of overcrowding, on sexual and mental health, which may be evidenced in high suicide rates.

The Prison Environment

An impoverished and overcrowded prison environment is the ideal setting for suicide, rape, consensual sex, injecting drugs and the spread of STIs to occur. The procedures set out for staff to avoid needle-sticks and bites, the precautions to take (for example, plasters, leather or disposable gloves) to avoid the risk of infection if blood, saliva or other body fluids come into contact with an open wound or get in the eye when dealing with violent or self-harming prisoners, uncovering razor blades or injecting and tattooing equipment during searches, and also dealing with contaminated objects confirm that they do (HM Prison Service 1999).

There is an acknowledged direct link between prison overcrowding and self-inflicted deaths – ten of 20 prisons in England and Wales with the highest incidence of suicides are also in the top 20 for population turnover due to overcrowding. In 2003, 85 (out of 138) prisons were overcrowded; 16,000 prisoners were doubling-up in single cells; occupation rates in the ten most overcrowded prisons were 154% to 184%; the Home Office predicted a 20% to 30% increase in overcrowding by 2010; and the suicide

rate had increased by 40% from 2002 with a third of suicides occurring among remand prisoners (Prison Reform Trust 2003; Howard League for Penal Reform 2004).

As well as threatening prisoner safety, overcrowding may lead to prison transfers which can disrupt drug treatment, make it geographically difficult to maintain family contact and, consequently, damage attempts to reduce reoffending (Prison Reform Trust 2003; Howard League 2004). It may also exacerbate staffing problems (sickness and shortages) – the increase in the prison population has not been accompanied by additional prison officers; new recruits have been outnumbered by departing staff in the ratio of 1:4 (Howard League 2004), and, according to the Prison Officers' Association, an extra 2,000 officers are needed (British Medical Association 2004).

Overcrowding and staffing problems interfere with efforts to meet key performance indicator (KPI) targets. In 2003, for the fourth year running, the prison service failed to meet its target for working with sex offenders – just 879 of more than 5,000 completed the sex offender treatment programme; and less than half of prisons met the KPI target of providing an average of 24 hours purposeful activity per week – Belmarsh Prison in London (which now houses a number of controversial detainees) provided the lowest level – eleven hours. Not only are black prisoners more likely to be given longer sentences, they are less likely to have access to constructive activities in prison and more likely to be found guilty of disciplinary offences. Also, some prisons have no staff from BME groups despite the large and increasing number of prisoners from these communities (Prison Reform Trust 2003).

Discussion

The escalating male prison population in the UK is 'high risk' for poor sexual health, especially the spread of STIs between prisoners and into the wider population, and the multiple consequences of being involved in sexually coercive incidents. Many prisoners are at increased risk because of alcohol and drug abuse (especially injecting) – drug dependency may be the motivation for crimes; use of drugs may continue in prison, on release, and play a part in reoffending; and drug treatment programmes have only had limited success, with some men becoming addicted to drugs in prison. Remand prisoners and those with mental health problems may be particularly vulnerable.

The huge scale of the UK's drug problem justifies focusing sexual health initiatives for prisoners on viral STIs (HIV, hepatitis B and C). However, the apparent lack of concern about the main bacterial infections (chlamydia and gonorrhoea) seems a serious oversight, given their escalating prevalence in younger men and men from BME groups (Public Health Laboratory Service 2001b), who are over-represented in the prison population, and because chlamydia, which is the focus of a national screening programme, can be easily and cheaply treated (Department of Health 2001). Although men from BME groups would appear to be at increased risk of involvement in sexually coercive incidents, and

consequently STIs, because of their large number of convictions for drug offences, longer prison sentences, less time engaged in purposeful activities, higher rates of mental illness, and lack of representation by staff (in terms of shared ethnic origin), they have not often been involved in incidents (Banbury 2004). However, it may be that racial abuse and harassment make them even more reluctant to report (Campaign Against Racism and Fascism Magazine (CARF56) 2000).

The link between sex and drug markets has serious implications for sexual health, especially the spread of STIs. If those involved in sex work are convicted, life on the outside, that is, selling sex, abusing drugs and pimping, may continue in prison. If drug addiction was a motivating factor for prostitution outside, so it may dictate type of 'customers', level of risk, and ability to stop on the inside, especially if reinforced by violence. Just as the 'social marginalisation' of sex workers (Scrambler and Scrambler 1995) hinders their take-up of health care services, many prisoners may also find it difficult to approach services for drug and sexual health-related problems. Since they have had a lifetime of social disadvantage and effectively been excluded from access to appropriate services in the past, despite high levels of need, prisoners may be reluctant to request condoms and report sexual assault in prison and seek advice and treatment on release, particularly when social attitudes to ex-offenders are tainted with prejudice.

Although the actual and potential for the spread of STIs in male prisons and YOIs has been recognised, harm reduction devices (condoms, lubricants, sterilised injecting equipment) are not easily accessible within the prison system, and this puts prisoners and staff at risk of contracting STIs, especially blood-borne viruses. This is compounded by the inadequacy and inconsistency in sexual health services, and prisoners on remand or with short sentences may just not be in prison long enough to finish a vaccination course for hepatitis B or a drug treatment programme. However, because screening does not routinely take place, we do not know the real extent of the problem of STIs in the prison population.

It is known that sexual health is particularly compromised in prisons because of lack of condoms. Given that prison is a punishment and sex (consensual) is a pleasure, it is understandable why there may be a dilemma about providing condoms, as seen in the 'practical' reasons put forward to prevent their issue, and processes in place which prohibit rather than encourage prisoners to request them (Roberts 2003). Prison administrators may indeed be justifiably concerned about the misuse of condoms for concealing contraband and not wish to send a message that signifies tacit approval of sexual relationships in prison. However, reluctance to provide condoms or make them more readily available may not just reflect conflict between the roles of prisoner and sexual being. It may also indicate a negative attitude to same-gender sex whereby sex between male prisoners is regarded as deviant and a challenge to the governor's authority. However, if prisoners do not have access to condoms and cannot protect themselves, this is a human rights issue.

The evidence from the US showing HIV/AIDS-related illness to be the second main cause of death in American prisons (Hensley 2000) is

alarming, and proof of the vulnerability of prisoners in terms of sexual health within a prison hierarchy and administration which allows or even encourages sexual assault to occur. If a hierarchy exists in UK prisons, it may be linked to length of sentence (long- and short-term or remand), to the age (old and young) of the predominantly male population, and type of offence (sex, drugs, violence-related); and the increasing influence of drug economies within and outside prisons has been noted. The older long-term or life prisoners (including sex offenders) are likely to have power and influence within the prison system, whereas the younger shorter-term or remand prisoners with drug problems or convicted of non-violent offences are likely to be more vulnerable and compliant, especially those who are in prison for the first time or who will be found innocent. If sex and drugs are commodities that are exchanged within and between these two prison populations, for each other, or for protection, pleasure, punishment, in repayment of a debt, or seen as a symbol of one's power, influence and status as a prisoner, and reinforced by violence, there may be considerable risk of acquiring STIs. Also, the myths associated with male rape, which are such an impediment to reporting this crime outside are magnified in prison, although both reporting and non-reporting may result in further sexual or physical violence, and may lead to suicide.

The high rate of suicide is an indication of an overcrowded and impoverished prison environment in which some of the behaviour that led to convictions can occur, especially when prisoners are doubling-up in cells. Prison overcrowding and staffing problems also lead to long periods of idleness, transfer to other prisons, cessation of treatment for drug dependency and sex offending and difficulty in keeping up family ties, which can increase the likelihood of sexually coercive incidents and reoffending. They, therefore, facilitate the spread of STIs by offering increased opportunities and time for consensual sex, rape and other forms of sexual assault, multiple-sharing of contaminated injecting equipment, and the occupation of several prisons in the course of one or more sentences.

The provision of equitable services is at the top of the government's health care agenda and the move to PCTs taking full responsibility for the health of prisoners in their locality embraces this ideal. It could be particularly positive from a sexual health perspective since it will reinforce the fact that prison is not an isolated environment in terms of the spread of STIs. Prisoners are sexual beings, and may also be injecting drug users, before, during and after time in prison, so STIs can be brought into prison, spread there, and to the wider population when prisoners are released. Therefore, the sexual and drug risk behaviours of prisoners, particularly 'revolving door' prisoners, are a particular threat to prison and public health.

Dealing with mental health problems and preventing suicide in prison has become the main priority; however, PCTs should not miss the opportunity to use the time men spend in prison, whether on remand or serving a sentence, to improve their sexual health. This is because STIs are already a major public health problem in the UK and untreated STIs in marginalised populations, such as those who spend time in and out of prisons and YOIs, lead to their transmission to new sexual partners,

re-infection of regular partners and, consequently, the growth of the epidemic. Despite the plethora of statistics on prisoners (and their offences), there has been little research on their sexual behaviour before being convicted, in prison, after release, or between sentences. Without this, and data on STIs brought into prison and transmitted there, sexual health information and HIV/STI prevention for people in prisons and YOIs cannot be appropriately targeted (Department of Health 2001), and the aim of preventing the deterioration of prisoners' health during or because of custody (HM Prison Service 2003b) cannot be realised.

As a result, and as part of a programme of research on sexualities and sexual health at City University, London, a qualitative study has been designed to find out about the sexual health and behaviour of male ex-prisoners in the UK, recruited via prison radio or after-care organisations: before they went to prison; time(s) spent in prison; between prison sentences (if appropriate); and, since release. It will involve collecting demographic data from participants; documenting their prison 'career'; exploring aspects of their life before going to prison and in prison which may be 'high risk' for poor sexual health, and also if their life has changed in any way since release in terms of sexual behaviour and health. This study will include ex-long- and short-term prisoners and men who spent time in prison on remand but were not convicted, who may be particularly vulnerable from a sexual health perspective. It will be an important step in developing knowledge and informing policy and service provision.²

Notes

- 1 Compared with the general population, prisoners are two-and-a-half times as likely to have had a family member convicted of a criminal offence, 13 times as likely to have been in care as a child, ten times as likely to have been a regular school truant and 20 times as likely to have been excluded from school, which may explain poor literacy and numerical skills and high unemployment levels: over two in three prisoners are unemployed at the time of imprisonment; one in 20 prisoners are sleeping rough before imprisonment; and, approximately a third of 90,000 prisoners released in England and Wales each year have nowhere to live (Social Exclusion Unit 2003; Prison Reform Trust 2003; Hollis and Cross 2003).
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