**Title: Victorian systems will not solve modern prison health problems**

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Prisons have been the default punishment for offenders in Britain since convict transportation to Australia was phased out in the mid-nineteenth century. Since that time, prison populations have grown considerably. The prison population for England and Wales is currently over 83,000, the highest total number of prisoners in Europe (not including the Russian Federation and Turkey). The most recent *World Prison Population List* also lists England and Wales with 148 prisoners per 100,000 population; a higher rate than countries with similar population levels in Northern, Southern and Western Europe, such as France (95), Germany (78) and Spain (136). This historically consistent high number of prisoners continues to have repercussions for the UK’s economy and public health. Offenders are more likely than the general populace to lead high-risk and unhealthy lifestyles, have complex health and social needs, and have low contact with health services when outside of prison. Yet, Victorian prisons and the ideas underpinning their design are still in use; an outdated prison estate, we argue, underpins soaring levels of prison violence, high prison staff turnover and, crucially, wastes opportunities for creating a modernised prisoner healthcare system. Although they were a model which was adopted across the world, these historic spaces experienced considerable problems in disease and prisoner management. The Victorian prison system was designed, as De Lacey (1986) said, to ‘grind men good’, but more often than not they consigned their inmates to poor health and scant chance of reform. This heritage, we argue, remains far too resonant.

The Victorian prison authorities walked a tightrope. They oversaw a system designed to be punitive enough to deter further offending through harsh conditions and hard labour (such as the treadmill or breaking rocks in quarries), but with a need to maintain low costs while keeping prisoners healthy enough to carry out this labour. Disease prevention was therefore a priority in prisons that that were overcrowded, poorly ventilated, and prone to infectious diseases. Efforts to overcome these challenges were bolstered by the Prison Reform Act (1877) which united both national and local prisons under the British government and began the modern prison medical service in England and Wales.

The Victorians recognised the importance of maintaining prisoner health because sick and diseased ex-convicts were economically and socially costly. It was crucial to sustain their health so that prisoners could work during their sentence and be healthy enough to secure employment on release. In pursuit of this objective, the health and biometric details of convicts were assiduously recorded by the prison authorities. These histories were collected and analysed as part of the Digital Panopticon project led by Liverpool University. The freely available and project website (www.digitalpanopticon.org) explains how the Victorians punished offenders and provides data on the lives of thousands of people who were either imprisoned in British convict prisons or transported to Australia. In order to evaluate convict health between 1853 and 1890, we have been working on a pilot study, using data from the Digital Panopticon to capture height and weight to calculate Body Mass Index (BMI) and standardised diseases from individual prisoners’ medical history using the WHO International Classification of Diseases (ICD10). Although the bodies of men and women have changed over time, the general trend has been for Western European generations to be taller and heavier than those in the past. We would expect a contrast in weight and height, but that BMI would enable useful comparison. Moreover, inadequate diet, nutrition and living conditions for poor and marginal populations in the nineteenth century leads to an expectation that convicts would enter prison malnourished; they would begin their sentence unhealthy and underweight and that they would most likely experience harsh conditions and substandard diet during their incarceration, exacerbating their poor health. In contrast, we found that most women and men arrived in prison within what would now be considered normal BMI ranges and most were in the same BMI category at committal and release. Surprisingly few convicts lost considerable weight in prison.

The medical records of 324 convicts (139 women and 185 men) that we examined indicate that prisoner health was more than a passing concern in Victorian prisons. Of those, more than two-thirds received medical treatment or attendance while in prison, many for more than one incident of illness. Men experienced more sickness than women but there were differences between the sexes in the range and severity of disease experienced. Whether from violence or work, the incidence of injuries was far greater in male prisoners. Women, though, presented with infectious and parasitic diseases at a higher rate than men– with sexually-transmitted disease, tuberculosis, scrofula and pleurodynia leading causes; they also suffered from musculo-skeletal and related tissue disease at twice the incidence of men. ‘Debility’ (physical breakdown or malnutrition) though was relatively common for both sexes – amounting to between a fifth and a quarter of documented disease, which was generally remedied by a stay in the infirmary and a more nutritious diet. Prison medical officers could treat disease effectively and they regularly recognised malnourishment. They played a key role in augmenting diet and getting prisoners back to health. Unwell prisoners were (at least, ostensibly) treated by skilled medical practitioners, capable of providing better health care to prisoners than they could access ‘on the outside’.

Most medical officers were physicians or surgeons at the height of their careers (and all males until the twentieth century). William Augustus Guy, for example, was Physician to King’s College Hospital and Professor of Forensic Medicine at King’s College London. For several years he was also Medical Superintendent at Millbank Prison. He published widely, including Guy's *Principles of Forensic Medicine* (1844), which was a standard work, running into several editions. The prison medical service was probably attractive to elite professionals like Guy because it provided a status that allowed them to practice with relative impunity and supplied a steady stream of convict patients for research (and publications).

In addition to their day-to-day rounds of treating prisoner patients, medical officers documented the biometric characteristics of prisoners. They decided who was strong enough for prison labour and who could withstand punishments, such as solitary confinement or a bread-and-water diet. Despite (or because of) the amount of illness they confronted, cynicism trumped sympathy. Men like Tennyson Patmore, medical officer of Wormwood Scrubs, warned against overly-harsh testing for ‘malingerers’ but were nevertheless scathing of those who used sickness to avoid prison labour or punishment:

‘Criminals undoubtedly appear to graduate with highest honours in malingering, which is not surprising considering what they have to gain by a successful exhibition, which may procure for the “insane” adept the genial luxuries of asylum life with its tobacco, cricket, dances, and so on; for the “rheumatic” expert rest from the treadmill and the crank; for the “dyspeptic” juggler white bread in place of brown, and cocoa instead of “skilly”; not to speak of the Elysian delights of the prison infirmary, where an undetected “paralytic” scamp may lie in ease and luxury…’

Prison medical officers had an experiential authority that was used to shape contemporary social theory towards emerging scientific ideas about eugenics in the last decades of the nineteenth century. They were examining mental illness, infections and ‘zymotic’ diseases (contemporary nosology for the contagion thought to have emanated from fermenting matter) on a daily basis, providing the medical profession with a unique set of data, not held to social norms of non-disclosure and confidentiality. The period which saw the growth of medical capacity in prisons also witnessed vast changes in medical professionalization and knowledge-production. The perceived moral and physical weaknesses of convicts were used as evidence of inherited criminal tendencies; and their poor mental-health signs of inherited mental degeneracy. This period pre-dates the rapid expansion of therapeutic psychiatry in the twentieth century, but for a time medical officers played an important (but misguided) part in developing ideas of the criminal mind. Eugenics-minded doctors were unsympathetic to mental illness in the prison and they undoubtedly under- (and mis-) diagnosed such disorders. As the nineteenth century progressed prison medical officers became powerful authorities due to the contribution they made to contemporary health and eugenic debates using the data they collected in the prisons in which they worked. Their story is one of risk, responsibility, and professional power, within the wider socio-political context of eugenics, penal, and medical power – creating an indelibly controversial heritage.

Today, a more sympathetic attitude towards prisoners’ complex health needs prevails in prison healthcare professionals, yet as a society Britons still tolerate huge numbers of prisoners suffering from mental health problems. Across the world, there remains wide disparity between the precise numbers of mental illness in prisons (due to contrasts in culture, diagnostics and research methods) nevertheless there are clear trends. Internationally evidence suggests that prisoners with a mental disorder are at increased risk of adverse outcomes including recidivism and premature post-release mortality compared with those without mental disorders. The most conservative surveys estimate that at least one in seven prisoners have major depression or psychosis – with clear links between mental illness and substance misuse. Both female and male prisoners have a raised risk of self-harm and are more at risk of suicide than the general population.

Modern society feels distanced from Victorian approaches to mental and physical health in prisons because medical science has brought curative and health benefits to everyone, including prisoners. Yet, we still lack an all-encompassing strategy, involving policies across different sectors, to manage the health needs of prisoners, reduce the inequities they face, and improve their wellbeing. Custody presents challenges but also an opportunity to rethink how we approach these public health issues; in the UK a multitude of organisations, including the Howard League, have argued that a clean break from the past is needed in order to better utilise spaces of punishment.

In 2006, the UK’s National Health Service (NHS) took over responsibility for prison medicine in England and Wales (and subsequently Scotland and NI), creating opportunity for change but also bringing a new set of challenges; not least in the funding allocation of health initiatives for a transient prisoner population. Lord Bradley’s report (2009) called for a national liaison and diversion service to better support people with mental ill-health, learning disabilities and autism, but the high proportion of prisoners that fall within its purview must surely dwarf any effort short of fundamental systemic reform. The Health and Social Care Act (2012) redistributed commissioning authority to Clinical Commissioning Groups and local government (augmented by the Better Care Fund) and local authorities were required to support needs in their area under the Care Act (2015). However, those developments may have unintentionally driven disconnected and sporadic approaches to managing prisoner health, and are at the mercy of huge cuts to local government funding. In 2017, the House of Commons Public Accounts Committee concluded that the Better Care Fund was ‘little more than a complicated ruse to transfer money from health to local government to paper over the funding pressures on adult social care’. In our opinion, the health of prisoners and offenders are not prioritised in this mire of conflicting funding pressures.

Ex-prisoners return to families and communities. Effective strategies for better managing and improving the mental and physical health of prisoner populations could improve lives, relieve stress on the NHS and cut costs for areas of the UK managing prisoner populations and their families. The challenges are significant but the costs will continue to rise exorbitantly if we remain rooted in a Victorian past.

**Further Reading**

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The Digital Panopticon: Tracing London Convicts in Britain and Australia, 1780-1925. www.digitalpanopticon.org.

**Conflict of interest declaration**

The data used in this article was originally collected for the AHRC-funded project ‘Digital Panopticon’ (www.digitalpanopticon.org), which has been completed.

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**Image No. 2:**

**‘Jebb’s Reformatory’**

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