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Clinical practice

Prevention of violence in prison – The role of health care professionals

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ABSTRACT

The World Health Organization (WHO) classifies violence prevention as a public health priority. In custodial settings, where violence is problematic, administrators and custodial officials are usually tasked with the duty of addressing this complicated issue-leaving health care professionals largely out of a discussion and problem-solving process that should ideally be multidisciplinary in approach.

Health care professionals who care for prisoners are in a unique position to help identify and prevent violence, given their knowledge about health and violence, and because of the impartial position they must sustain in the prison environment in upholding professional ethics. Thus, health care professionals working in prisons should be charged with leading violence prevention efforts in custodial settings.

In addition to screening for violence and detecting violent events upon prison admission, health care professionals in prison must work towards uniform in-house procedures for longitudinal and systemized medical recording/documentation of violence. These efforts will benefit the future planning, implementation, and evaluation of focused strategies for violence prevention in prisoner populations.

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1. Introduction: Prevention of violence in prison- A call to action for health care professionals

In accordance with worldwide laws,[1,2] rules, recommendations and declarations[3–6] prisoners have the "right to a safe and healthy environment"[7]- this includes the right to protection from all aspects of violence. Despite international consensus on various position documents, and contributions from prison law enforcement officials, custodians, and guardians, violent perpetration and victimization continue to be an everyday reality in many prisons all over the world. For one, many prisoners already possess risk factors that are associated with being a perpetrator and/or victim of violence. They include: young age, male, family history of abuse or neglect, low socio-economic and educational status, unemployment, mental illness and drug dependency.[8] Next, these already vulnerable individuals enter the context of a "total institution"[9] (prison) which can be further de-stabilizing. The prison environment has been well documented as a trigger for violent behavior. Deprivation of liberty, oppressive conditions, overcrowding[10,11] and impunity of violence (in some penitentiary systems) have been known to be associated with violent incidents.

The WHO Report on Violence[8] sheds light on the victimization of certain vulnerable groups like children, adolescents, women and the elderly. However, little, if any mention, is made about imprisoned persons, a particularly vulnerable population with respect to violence.

As reflected in current theories that address the issue of prison violence, approaches for violence prevention up until this point have really only dissected this issue as a subject which solely concerns custodial officials, instead of including a role for health partners in the discussion.[12,13] The scope of this paper is to examine the role that health care professionals can take for the prevention of violence in prison and other custodial institutions. This perspective actually mirrors the community-based Global Campaign for Violence Prevention, which advocates for a close partnership between public health services and police/criminal justice systems for community violence prevention.[14] Prison policies for violence prevention should closely model community policies, which already value the role of the health care professional and meaningful partnership between public health and custodial officials. Like for any other health care promotion/preventive activities, the ethical medical principle of equivalence of health care applies.

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2. What do we know? Definition, prevalence, and the impact of interpersonal violence in prison

The WHO defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in, or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.”[15] To clarify the scope of this paper, we should mention that suicide and other “self-harm” prevention efforts in prison have been thoroughly addressed by WHO documents and other publications,[16–18] while “collective violence” (prison riots), is outside the likely sphere of influence for many health care providers. Thus, to simplify, we confine this present discussion to interpersonal (person-to-person) violence by physical, sexual and/or psychological attack, and abuse/neglect.

Data on the prevalence of prison violence have been obtained mostly by anonymous surveys of current or former prisoners. However, the interpretations of these surveys are limited by low/modest response rates, varying methodologies and different definitions (inclusion criteria) for violent events. Because interpersonal violence is the result of a complex interplay between individual, socio-cultural and environmental factors, the results of the limited available studies are not fully representative of the complete issue. Nevertheless, they can begin to outline the magnitude of the problem.

A prior survey of 13 American state prisons (7221 male and 564 female participants, out of roughly 19,000 prisoners), reporting on the past six-month period, found that inmate-on-inmate physical violence was experienced by 13%–35% of all prisoners; staff-on-inmate violence was reported by 8–32%.[19] Sexual victimization was reported by 4% (inmate-on-inmate) and 8% (staff-on-inmate) of male prisoners; among female prisoners, sexual violence was 21% (inmate-on-inmate) and 8% (staff-on-inmate).[20] In addition, inmates with a prior history of mental health disorders had a higher risk for physical[21] and for sexual victimization.[22]

Results of roughly the same magnitude were found in a recent survey of 33 prisons in north and east Germany: more than 25% of males and females of the 6384 participants (nearly 12,000 prisoners total) reported being physically victimized in the prior four-week prison period. Among males, 5% reported sexual assault, with 4% among women. Indirect (i.e. non-physical) victimization included verbal/psychological assault or theft, and was experienced by more than half of the respondents in the past 4-week period. The authors estimated that their results, at best, shed some light on the lower limit of prison violent events; the numbers in reality, are likely much higher.[23]

The United States Bureau of Justice Statistics via the Prison Rape Elimination Act of 2003 administers the largest surveys on violence- but these are, of course, limited to reports of only sexual violence. In its most recent National Inmate Survey, 4% of the more than the 92,000 participating inmates reported that they experienced at least one incident of sexual victimization by another inmate or facility staff member in the past 12 months.[24] In the National Former Prisoner Survey, based on over 18,000 interviews, 9.6% of former state prisoners reported at least one incident of sexual victimization during their most recent period of incarceration in a jail, prison, and/or post-release community-treatment facility.[25] In the National Survey of Youth in Custody, an estimated 9.5% of the 8707 adjudicated youth in state juvenile facilities and state-contract facilities who participated in the survey reported experiencing one or more incidents of sexual victimization by another youth or staff member in the past 12 months.[24]

There is a scarcity of medical reports on injuries suffered at the hands of prison violence.[26,27] The “enhancement of capacity for collecting data on violence” by health care staff (as recommended by the WHO[8]) and the “systematic recording and compiling of periodic statistics” on violence by health care professionals working in prisons (as proposed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment (CPT),[3] are lacking in most correctional facilities. As one unique example, the 2010 Clinical Indicators of Sexual Violence in Custody study (U.S. National Institute of Justice and the Centers of Disease Control and Prevention) did propose the use of medical indicators and medical surveillance methodologies for the collection of sexual assault data in prison on a national level. However, the study was later deemed “not feasible” by the U.S. Bureau of Justice Statistics, and henceforth, has not been pursued since.[24]

Physical injuries have been reported for 40% of physical assaults,[23,28] and 67% of sexual assaults.[28] Data on the psychological/emotional short and long-term trauma of interpersonal prison violence are also important. These include pathological anger (instigating further violent behavior), depression, post-traumatic stress reactions, fear, “fight or flight” maladaptive responses, and inescapable paranoia/insecurity for one's welfare.[23,28,29] In two studies, psychological trauma developed in over half of all victims.[23,28] Transmission of sexually transmissible infections in prison, through sexual assault, is a common report in many parts of the world.[30] However, less than a third of the assaults received medical attention or were brought to the attention of medical authorities[28] (the numbers are actually lower for staff–on-prisoner sexual assaults).[28]

3. Challenges for prison administration and custodial staff colleagues

The inherent structures within prison pose a serious problem for prison staff trying to address violence prevention solely through the legal/custodial perspective. For example, following trauma in prison, victims of violence tend to seek protection through alliance with a gang for protection (these individuals then fight violently for power and influence in prison against other gangs, as part of the group).[31] In addition, several penitentiary systems passively enforce unofficial prisoner hierarchies, organized in cast-like structures, where certain individuals control money, goods and drugs in prison by violent means, often with tacit acquiescence by prison staff and administration.[32] Clearly, it is a complicated and multifaceted issue where one act of violence begets more violence.

Although various theory models on the response to violence in prison exist, prerequisites for any prevention programs will require the engagement from multiple parties. Health care professionals can help in the partnering discourse. This engagement includes a strong commitment to the defense of human rights by all stakeholders, a sufficient number of staff in relation to the number of inmates, appropriate staff training and supervision, and a policy and everyday practice of non-tolerance of violence among all staff and inmates within the prison.[12,13]

4. A new source of aid in the prison violence prevention model-why health care professionals should partner

Until recently, health professionals in the community and in prison limited their violence role to the medical care of victims post a violent event: diagnostic examination, treatment, documentation of trauma in the individual patient file and reporting the case to the authorities for prosecution (with or without consent of the victim, depending on the national law). Today, the WHO stresses an active role for the health sector in the prevention of violence in the community.[8] Similarly, health care professionals working in prison should prioritize this mission, particularly because, according to

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