

## **Justice Committee**

### **Transfer of prison healthcare to the NHS**

#### **Written submission from Dr Lesley Graham**

Whilst on secondment to the Scottish Prison Service (SPS) from 2006 to 2008, I conducted a health care needs assessment [1]. The purpose was to describe, as comprehensively as possible, the health of prisoners in Scotland, conduct a gap analysis of healthcare service provision and make recommendations for addressing those gaps. It was also to provide part of the evidence to underpin the submission to Scottish Ministers for the transfer of healthcare from the SPS to the National Health Service (NHS). At that time in SPS, although there was a bespoke primary care IT system (Gpass), it had not been fully implemented across the estate with use instead of paper records. This meant that there was not an easy way to capture, analyse and report on information on prisoner health. Nor was the full range of enhanced primary care captured on that system (for example, enhanced addiction services). Additionally there was evidence that there was under-recording in the Gpass system. A range of different data sources were therefore required to be drawn from and 'triangulated' to provide an overall picture [1].

I will describe a brief overview of the health of prisoners, from both the needs assessment, from the (limited) range of other routine data sources and from Scottish based research studies and reports. Prisoners are predominately young, male and from disadvantaged backgrounds. In general, they have a higher burden of ill health than the general population, particularly in mental health and addictions. For example, 73% were positive for illicit drugs on admission [2], 73% of prisoners had an Alcohol Use Disorder with 36% probably alcohol dependent [3], 76% smoke [4], 4.5% have a severe or enduring mental health problem [5], 19% were Hepatitis C positive [6] and there are higher rates of long term conditions [1].

Whilst at SPS I also led on a Chief Scientist Office funded research study on the mortality of prisoners in Scotland through linkage of prisoner records from the SPS prison administrative system (PR2) with death records. The results are as follows. Compared to the general population, the risk of dying (Relative Risk or RR) was 3.3 times higher in men who had been in prison and 7.5 times higher in women. This confirms findings from other international research on prisoner mortality. It is possible that this excess mortality risk could be explained by deprivation given that many prisoners come from deprived areas. However, after taking that into account, the risk of dying was still 2.3 times higher for men and 5.6 higher for women. In other words, deprivation accounted for part but not all of the excess mortality risk in both men and women showing that there is an additional mortality risk from imprisonment distinct from deprivation alone.

Among men the risk of dying from suicide was 3.5 times higher (than the general population); for homicide it was 4.4 times higher; it was 4.4 times higher for drug related causes and 2.9 times higher for alcohol related causes. The corresponding figures for women are 11.4 times higher for suicide; 22.2 times higher for homicide (although numbers are small); 19.0 times higher for drug related causes and 9.3 times higher for alcohol related causes. There was a higher risk of dying in younger

age groups. When examining risk of mortality by length of time and number of stays, the highest excess mortality for men was seen in those with a short total duration but with multiple prison episodes providing evidence that short term, multiple sentences are a high risk. A similar but less consistent pattern was seen in women. The risk of dying whilst in prison compared to out of prison was also explored. For men, the risk of dying in prison was *lower* than in the general population (RR 0.6) although this was of borderline significance. The risk for women of dying in prison was more than three times that of the general population although lower than the overall RR of 7.5 (see above). Mortality rates for both sexes outside of prison were *much higher* than the general population (RR of 6.2 and RR of 13.6 for men and women respectively). The greatest number of deaths occurred shortly after release from prison [7].

In December 2011, following my return to my post as Public Health Lead for Drug Misuse and Alcohol Problems at ISD, I was also invited to join a workstream of the National Programme Board for Prisoner Healthcare. This met from January 2011 until the close of the programme prior to transfer in November 2011. The original remit was to:

- (1) *Design a performance management framework to monitor improved outcomes in access to services; health outcomes in a prison setting; a reduction in health inequalities and a reduction in re-offending.*
- (2) *Determine if it is appropriate to undertake an evaluation of the performance of the Programme Team to date in relation to, for example, effectiveness, value for money.*

The group reached agreement that Performance Management for prisoner healthcare would be as for the NHS (e.g. HEAT targets, the Quality Measurement Framework of the Quality Strategy) but did not reach the objective of agreeing a set of monitoring indicators. This was taken forward as a 'legacy issue' to the National Prisoner Healthcare Network (NPHN) which was established post transfer supported by Healthcare Improvement Scotland. It was subsequently agreed that the evaluation of the Programme would be outwith the remit of the workstream.

Performance management/health outcome monitoring was identified as a high priority for the NPHN workplan and a dedicated workstream was to be set up. I was invited to become a member of this which met for the first time in October 2012. A proposed set of indicators has already been drawn up and the next step is to identify which of these indicators are possible to measure from routine data sources. This will include the new bespoke IT system (Vision) for all prison health care centres which is hosted by Grampian Health Board.

Additionally, I had been asked to join an informal group led by the Drug Policy Unit in Scottish Government and included policy representatives with a particular interest in prisoner health such as alcohol policy and mental health. This has met on several occasions and has also identified the need for monitoring prisoner health outcome indicators. As I understand, there is not an individual policy lead for prison health at present.

In conclusion, prisoners are a group that have worse health and greater healthcare needs than the general population. There is not a routine reporting process to be able to monitor their health outcomes at a national level at present. This means that

it is not possible to easily answer the question whether the health of prisoners has improved, stayed the same or has worsened post transfer to the NHS.

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