Scottish Directors of Public Health and NHS Health Scotland
Response to the Scottish Parliament Health and Sport Committee Call for Evidence regarding Healthcare in Prisons

28 February 2017

What do you consider are the current pressures on health and social care provision in prisons?
How well do you consider that these pressures have been responded to?

In line with the recommendations of the WHO in Europe\(^1\), the provision of health care for Scottish prisoners is provided by the NHS. This ensure that prisoners are entitled to the same range and standard of care as that received by the general population. This expectation is set out in the national memorandum of understanding between the Scottish Prison Service and the NHS in Scotland.\(^2\)

To understand the current pressures in the existing health and social care provision in prisons presumes that a sound system for gathering health intelligence exists to inform an understanding of both health service provision requirements and health outcomes for prisoners. However, in Scotland we presently have no such national capability around our prison healthcare systems. Efforts to extract intelligence from the prison healthcare clinical system (‘Prison Vision’) have been frustrated by a combination of the technical shortcomings in the way this system was been set up and is used. There is an urgent need to address this governance issue and ensure that we have a system capable of the systematic measurement, collection and reporting of health and social care needs, services delivered and (importantly) outcomes, in order to:

- inform priorities for care and support by providing a better understanding of who is in our care and what their needs are (e.g. the needs of women in custody);
- identify gaps in service provision;
- evaluate services, interventions and cost-effectiveness; and
- monitor outcomes and their impact on inequalities;
- provide effective governance.

A full understanding of the needs in the prison population also requires qualitative data sources exploring patient and staff needs and experience.

The absence of an agreed national approach to identify health and social care needs, service provision, and health outcomes presents a considerable barrier for prison health care provision. Resolution should be a pressing priority. What this requires is outlined below.

At present, the only avenue open to assess current pressures in health care need is through consideration of what we know from the literature and from SPS prisoner survey. People in prison experience disproportionate levels of poor health and wellbeing. Evidence suggests this is a long-standing issue\(^3\) and one which is potentially increasing with high levels of health care


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needs being identified. Current work by the Scottish Prison Service is likely to show this to be the case for social care needs as well. Available evidence suggests that the prison healthcare system is responding to the health and social care needs which were previously unmet prior to incarceration. These inequalities, however, can only be mitigated within prison as incarceration serves to make more visible the established inequalities which individuals experienced prior to imprisonment.

The prevalence of poor mental health is higher among prisoners than the general population and there is a long-standing concern that the prison environment may have a detrimental impact on the mental health of prisoners. Substance misuse, whether tobacco, alcohol or drugs is also highly prevalent amongst prisoners. The physical health of prisoners remains poor. Given the ageing of the prison population, the need to manage and support of prisoners with long-term conditions (e.g. asthma, chronic lung disease and cardiovascular disease), is increasing; requiring care of greater complexity to meet health and social care needs. Sexual health in prisons is also an area of potential concern; especially the high proportion of prisoners with histories of trauma and physical and sexual abuse, especially amongst women detainees. There are relatively low levels of HIV and Tuberculosis in Scottish prisons; however, the prevalence of Hepatitis C is significantly higher than in the community, reflecting the widespread practice of intravenous drug use amongst prisoners before detention. Prevention and/or early identification of communicable diseases and their risk factors must remain a priority in Scottish prisons (e.g. protection against vaccine-preventable diseases; universal opt-out blood borne virus screening, opiate substitution). Finally, consideration also needs to be given to a number of specific “communities” within the general prison population that are likely to have specific needs. These include women prisoners, young people in custodial settings, and those with learning difficulties or other cognitive impairments (e.g. acquired brain injury, dementia).

It would be appropriate to highlight the positive contributions to the health of prisoners made by SPS staff. For example, the development of mental health first aid as a core skill within the Prison Officer workforce has been transformational, as has the general approach by the agency to suicide prevention. Whilst the handover of responsibility of prison healthcare from the SPS to the NHS has heralded further development in health care, delivering quality healthcare services in prisons is a complex undertaking, hampered by not only the high level of need amongst prisoners, but also the constraints of the prison environment as a setting for care, and the constant need to build and sustain good relationships to ensure effective operation of all services in the setting. Factors such as overcrowding, separation from family and friends, boredom and loss of autonomy have all been

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identified as being potentially detrimental to health and wellbeing. Release may also bring uncertainty with regard to reforming relationships, arranging housing and regaining access to children, and reconnecting with community-based support services.

Ensuring effective continuity of care from prison to community remains challenging.⁸

As with any occupational setting, a prison is also a place where the health and wellbeing of its workforce is important. Ensuring that both the SPS and NHS workforces are appropriately supported is also a key consideration in addressing health and health care needs. Maintaining and improving the health and wellbeing of the staff can only have a positive effect to ensure delivery of an efficient and effective healthcare service.¹

To what extent do you believe that health inequalities are/ could be addressed in the prison healthcare system?

Many of the communities from which offenders come to prison and to which prisoners return are some of the most underserved communities in Scotland and experience some of the highest levels of multiple deprivation, where health and wellbeing outcomes are frequently amongst the worst in Scotland.⁹,¹⁰ The social patterns found within prisoners indicate both inequalities and missed opportunities to intervene and prevent offending. There are for example, very high correlations between income inequality, low social mobility, teenage births, adverse childhood experience, prior imprisonment, levels of trust, as well as markers of poor physical and mental health.¹¹

While evidence demonstrates that, where appropriate, alternatives to imprisonment afford more effective opportunities to improve health and wellbeing, time spent in prisons represents an opportunity to provide care and support for some of our most vulnerable and difficult to serve individuals. As such, work to improve health and wellbeing for those in prison has the potential to pay public health dividends far beyond the prison walls: reducing inequalities; reducing reoffending; and contributing towards healthier communities.¹² In the prison health care setting this means care should include the consideration of emotional, physical and social needs. Recent work by the Scottish Prison

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Service to explore the social care needs of those in prison will be very helpful in informing the last of these. Taking a person-centred approach, efforts in this area should have at their core the individual’s journey from community through custody and back into the community. Time spent in custody and the transitions in and out of prison afford opportunities to influence factors closer to individuals by improving health, increasing educational attainment and employability, supporting income maximisation, facilitating secure housing and improving interpersonal relationships.10

Crucially, however, an individual’s health and wellbeing is influenced by a wide variety of factors (beyond care for ill-health). The fundamental causes of the inequality that give rise to health inequality are socially, economically, environmentally, and politically determined.13 It is important to recognise that the inequalities which prisoners experience originate within communities and are often an indicator of missed opportunities for earlier intervention by health, justice and other services. Addressing inequality therefore relies more on earlier intervention which prevents offending behaviour, or measures and responses that divert individuals away from a prison sentence (including use of remand). Public services, both NHS and wider partners have to work together effectively to reduce the negative impact of such behaviours and use the new model for community justice as an opportunity to steer individuals, families and communities towards hope, recovery and resilience. This requires much greater recognition of the need for effective partnerships between the NHS, SPS, Local Authorities, the Community Justice Authority and the third sector in order to develop a health-promoting and health sustaining environment through and beyond Scottish prisons, engaging social and public health models of approach aligned as much as possible with the requirements of legal justice.

What are the current barriers to using the prison healthcare system/ improve the health outcomes of the prison population?
Can you identify potential improvements to current services?

From an NHS perspective delivering effective and efficient services is predicated on there being adequate health intelligence to allow an understanding of what services are provided, where, the quality of care delivered and the overall performance of the system. Such data exists within NHS generally, as noted above, it is lacking with the prison setting. Addressing this situation would require:

- national co-ordination and leadership to create and implement change;
- the commissioning of a functional, national IT solution to support health care delivery, support transitions from prison into the community, and provide essential information for planning and evaluation;
- support to facilitate practice change in data collection by practitioners; and
- support to extract, analyse, interpret and disseminate data locally and nationally;
- a clear governance structure and improvement model.

In the absence of such a system, it is difficult to be more specific concerning what needs to change to allow improvements to occur. From anecdotal evidence, it is likely that:

- persisting differences in the access to health promotion and health care provision within and between prisons in Scotland will mean that inequalities in access will allow health inequalities to remain unaddressed;
- maintaining an appropriate focus on meeting the healthcare needs of women, young people and those with learning difficulties is challenging;
- differences in throughcare and aftercare of prisoners may mean that health outcomes achieved within prisons are not sustained in the community; and
- the health of the prison and the healthcare workforces will need to be supported and improved.

Nonetheless, there are models of good practice in Scotland; the challenge is to recognise them, and apply the positive lessons of these achievements.

What do you think the main pressures will be in the next 15 years?

Predicting future pressures first requires a clearer understanding of the needs of those currently in our prisons. Influences on future pressures will likely include our ageing general population (although the average age of those in prison will likely remain relatively young) and increasing demand on health and social care provision in the face of diminishing resources.