Scottish Prisoner Advocacy and Research Collective (SPARC) Submission to Committee on Health and Sport – Call for Written Views of Healthcare in Prison

February 2017

SPARC (Scottish Prisoner Advocacy and Research Collective) is a research and advocacy collective on Scottish imprisonment comprising researchers at all stage of career and many with long-term, personal experience of imprisonment. We come from universities across Scotland, including Edinburgh, Glasgow Caledonian, Open, Dundee, Strathclyde and Glasgow Universities. As a newly formed group we are still firming up our mission but the health and wellbeing of those in prison will figure centrally in it. Hence we welcome the Health and Sport Committee’s call for views on this issue.

1. What do you consider are the current pressures on health and social care provision in prisons?

2. How well do you consider that these pressures have been responded to?

In general, the move from SPS healthcare provision to the NHS has been a positive development as it moves Scotland towards a vision of the person imprisoned as a full and equal member of Scottish society, with the same rights to care as anyone else. However, evidence to date suggests that in practice this commitment has not been realised. Here we refer to the Royal College of Nursing Scotland’s comprehensive review of this transfer Five Years On (2016). We are sure the Committee is fully aware of this report but we wish to be added to the voices of those seeking for its powerful findings to be taken into account. We find its method and approach robust in flagging up key issues in provision of health and social care for those in prison.

The key pressures this report identifies, and which is consistent with our own experiences and awareness of the research relate to:

- An inability to adopt a prevention focus due to extensive staff time devoted to medication management of those in prison;
- Lack of continuity in care before, during, and following a prison sentence impacting on the cost effectiveness and efficiency of health care delivery in prison;
- Relatedly, this finding suggests more than coordination issues between SPS and NHS staff but a more fundamental need to understand and address possible organisational culture differences between health and punishment sectors – from experience we have seen ‘prison security’ and prison personnel staffing issues affect medical delivery (for example, the timings of medication rounds is a direct function of prison and NHS staff shift times and prisoners may receive an evening dose at 4 in the afternoon on weekends, when prison staff levels means after this many are locked in cells). In addition, NHS staff should never, under any circumstances, be required to provide medical interventions to primarily support SPS security and control, this violates the principles of equitable medical care and erodes trust between prisoners and medical staff. Nor should medical staff prescriptions or
treatment plans be amended post hoc by SPS. Instances of both have been seen or experienced by members of this group;

• Finally, **staffing levels and pressure** generally on staff emerged as a consistent finding and one which requires consideration to maximise optimising health care, outcomes, prevention focus and effectiveness and efficiency issues; however, a core concern of our collective is to ensure that problems within the prison system do not become arguments for expanding the prison system or expanding the prison’s budget compared to other settings where health and other outcomes (i.e. the community) are better supported. Hence, we express concern about the repeated use in the RCNS report of the idea that ‘prison offers the best chance of catching people’ and addressing their health needs. Prison is never the best place to work with people, all other factors remaining equal.

• **Lack of data** and understanding of health issues and provision gaps: The RCN wrote that: ‘It is not possible to evidence the impact that the transfer has made on tackling health inequalities and addressing the health care needs of people in prison. This is because there are still some gaps in our understanding of people’s health needs in the criminal justice system and a lack of national reporting and quality outcomes data for prison health care’. An annual prison health report on the existing health inequalities, systemic improvements and kinds of provisions that make up the NHS work, e.g. budgets, would be useful to ensure continual prioritisation and awareness of the issues. The Government needs also to demonstrate more explicitly how prison healthcare is integrated in their national vision of stronger, safer, fairer and healthier Scotland. Therefore, prison healthcare must be recognised as a distinct area of service provision within the long-term strategic plans for Scottish health. Finally, the lack of data reflects wider gaps and progressive loss in knowledge: for example, the most recent published statistics on the prison population date from 2013-14 (with significant disinvestment of resource in producing official statistics on prison populations in Scotland in the past 10-15 years). Effective policy making and transparent democracies require clear and open understandings of who is imprisoned, where, why and for how long. We are concerned that prison healthcare will fall under the same opaque reportage and loss of public oversight.

The fact that 66 **deaths in prison custody** since 2013 remain undetermined (SPS website) receives far too little Government and policy scrutiny despite extensive recent media coverage:

• The scandal of unexplained deaths on Scottish prisons [http://www.scottishreview.net/KennethRoy158f.html](http://www.scottishreview.net/KennethRoy158f.html)
• Scottish prisons fail to protect inmates at risk of suicide [https://theferret.scot/scottish-prison-deaths/](https://theferret.scot/scottish-prison-deaths/)

Staffing and other resource issues likely play into this, but we challenge those concerned with the health and social care of those in prison to prioritise explaining, resolving and providing closure to families of people who die in state custody.

We are not aware of national reporting on prison healthcare and would welcome some mechanism for this. However, we also worry about the emphasis in the RCN report on inadequate assessment of health needs. While we welcome better understanding of these needs, it is important to set this in the context of extensive, almost **relentless and often dehumanising assessment processes in prison** where people are regularly required to recount multiple times issues of deep personal concern such as personal traumas, drug and alcohol issues, literacy issues, abuse issues and more. We urge a focus on care, prevention and positive, supportive relationships with professionals over endless inquiries (often in front of multiple strangers) in order to achieve perfect recordkeeping.

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

### 4. What are the current barriers to using the prison healthcare system/improve the health outcomes of the prison population?

Health inequalities cannot be addressed effectively when health is viewed as a factor in reduced offending: The new NHS model of prison healthcare has sometimes been presented and justified as an improved form of medical provision primarily because it will help with reducing reoffending\(^1\). This directly **undermines an agenda of reducing health inequalities** because it implicitly values NHS provision in prison mainly in terms of its contribution to crime reduction. Healthcare, whether in prison or anywhere else, should be discussed only in terms of treating people who are in need, supporting citizens and improving health and wellbeing in Scotland in general. Prison healthcare should be motivated by the same ethos and vision as the recent National Clinical Strategy for Scotland which stated that: ‘Quality must be the primary concern – all developments should seek to ensure that there is enhancement of patient safety, clinical effectiveness and a person-centred approach to care’\(^2\). A key challenge to rectifying health inequalities, therefore, is the dominant ethos of the prison system in which all services delivered in this setting are assessed instrumentally in terms of reoffending outcome measures.

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\(^1\) E.g. Michael Matheson: ‘However, factors outside of the control of the criminal justice system affect reoffending. The work of this group has found that reoffending is a complex social issue and there are well established links between persistent offending, poverty, homelessness, addiction and mental illness. When transitioning from custody to the community, gaps in access to vital support services and basic needs can hamper attempts to desist from offending’ [http://www.nphn.scot.nhs.uk/wp-content/uploads/sites/9/2015/11/Ministerial-Group-on-OffenderReintegrationReport-2015.pdf](http://www.nphn.scot.nhs.uk/wp-content/uploads/sites/9/2015/11/Ministerial-Group-on-OffenderReintegrationReport-2015.pdf)

Health inequalities cannot be effectively addressed without recognising the harms of prison itself: Prisons, no matter how well they are run or designed, are innately damaging. Reviews of research suggest that time in prison is itself damaging to cognitive function\(^3\). Research on Scotland by Prof Lesley Graham has further established that those who are in prison have higher mortality rates, of two to more nearly six times higher, than those in the general population, even when controlling for social deprivation\(^4\). Such work establishes, unsurprisingly, that confinement of human beings is deeply damaging, and this damage should be carefully considered. A discourse has emerged of talking about people in prison as having lower cognitive function, greater health needs, more chaotic lives and so on; and while this may have some evidential support, it diminishes those in prison as a damaged ‘them’ and obscures the extent to which being in prison itself is a health risk and a mortality risk.

Importantly, this risk to health and wellbeing extend beyond the person in custody. Drawing on large-scale US survey data, Wakefield and Wildeman found that the prison has become an institution which creates and reinforces deep social inequalities, increasing the risks of poor mental health, homelessness and infant mortality for children of an incarcerated parent\(^5\). While imprisonment rates in Scotland are not comparable with America’s “prison boom”, it is nonetheless clear that supporting a person in custody requires large investments of time, emotional support and financial resources from some of Scotland’s poorest families and communities. Positioning families as a source of support to render prisons more “survivable” is therefore at odds with adopting a prevention focus or reducing wider health inequalities.

Health inequalities, therefore, cannot be addressed effectively until the harms of prison are addressed, and this includes taking into account Scotland’s high imprisonment rates in policy making and reform. This point also emphasises why we should never talk about prison as ‘being the best chance’ to deliver any public service. If the prison system operated adopted a Hippocratic oath, we would have strong doubts that it is achieving this.

Signed,

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\(^4\) Justice Committee, Transfer of prison healthcare to the NHS Written, submission from Dr Lesley Graham: [http://www.parliament.scot/S4_JusticeCommittee/Inquiries/Dr_Lesley_Graham.pdf](http://www.parliament.scot/S4_JusticeCommittee/Inquiries/Dr_Lesley_Graham.pdf)