Scottish Parliament Health and Sport Committee: Inquiry into healthcare in prisons
March 2017

“I don’t know, like, just every time I’m drunk I just seem to always end up in here” (Study Participant G)

Introduction
I would like to thank the Health & Sport Committee for calling this Inquiry and giving myself and others the opportunity to provide evidence regarding prisoner health in Scotland. I am a Registered General Nurse (RGN) and a member of staff in Nursing Studies at The University of Edinburgh, where I am Professor of Nursing Studies. I have spent the last 20 years studying and working with those affected by alcohol-related harm, developing and evaluating interventions and exploring the nurses’ role in responding across a range of settings and populations. I secured funding in 2015 from the Medical Research Council (MRC) Public Health Intervention Development fund to explore the feasibility and development of alcohol brief interventions for male remand prisoners [1]. The study aims to explore:

• how feasible it is to deliver alcohol advice and information to male remand prisoners
• who is best placed to deliver alcohol advice and information to male remand prisoners, when and in what way
• what male remand prisoners feel would be the most useful type of advice and information to receive
• what service providers e.g. prison nurses, prison officer, peer prisoners and health and social care agencies, feel are the barriers and facilitators to providing alcohol advice and support to male remand prisoner.

This evidence contains some of the findings from a Scottish prison that took part in our UK study [PRISM-A] (June 2016 – January 2017). This includes survey results and specific quotes from one-to-one interviews with male remand prisoners who have spoken to us about what they feel is needed to help them address their excessive alcohol consumption, both inside and outside prison, and how this would help them address their offending and re-offending behaviours. These are accompanied by some of the findings from the stakeholder group interview, involving those who are part of the delivery of health and social care and specifically alcohol interventions/support in prison and on liberation. (A full report of the study findings is available to the Committee on request).

Prison as an opportunity to invest in alcohol-related prisoner health
Harmful alcohol use impacts substantially on individuals’, families and society, resulting in significant health, economic and social burdens [2]. A disproportionate level of health inequalities is experienced by those individuals within the criminal justice system [3] with evidence identifying links and relationships between health and crime [4]. Remand prisoners are often those whose rates of re-offending are highest. Those who have offended, or are at risk of re-offending, frequently suffer from multiple and complex health needs, including mental and physical health problems, learning difficulties, possible Foetal Alcohol Spectrum disorder (FASD), substance misuse and increased risk of premature mortality. Offenders have also been identified as having a higher prevalence of alcohol problems when compared to the general population.

Prison therefore, offers a public health opportunity to prevent, diagnose and treat those with health problems in a potentially cost-effective way. If this opportunity to intervene is consistently missed, remand prisoners may return to communities and a ‘revolving door’ relationship with prison, the criminal justice
system and reoffending occurs. In turn, this increases individual and wider social and economic burden, potentially impacting on future productivity, particularly for those of working age.

What do you consider are the current pressures on health and social care provision in prisons?
One of the key current pressures is responding to the health and social care needs of remand prisoners. This is particularly the case in relation to alcohol-related harm.

“I’m glad they’re finally getting something done for.... remand prisoners.” (Study participant A)

Of the 150 male remand prisoners that we surveyed in a Scottish prison, 94% were White British, 92% were single with an average age of 33 years. One hundred and forty-seven male remand prisoners completed the Alcohol Use Disorders Identification Test (AUDIT) ‘gold standard’ screening tool as part of the survey, with 80% having a positive score. This translated into 20% being classified as hazardous drinkers, warranting simple alcohol advice; 10% as harmful drinkers, warranting Simple Advice plus Brief Counselling and Continued Monitoring; and 49% classified as probably dependent drinkers, warranting referral to specialist for diagnostic evaluation and treatment.

These results demonstrate the extent of alcohol-related harm experienced by male remand prisoners and the type of screening and intervention service they require. During interviews, male remand prisoners consistently voiced their awareness that for them, there was little access to services and support in comparison to sentenced prisoners.

“When your convicted there’s a lot of help that you get over there....but when you are remanded they just chuck you in and they don’t bother....and they get out and they’re back to square one....just say I got out when I went to court or not really had the help with my drink and that. They’ve just chucked you in, because they’re saying you’re remanded you’re not guilty yet but it’s like we are guilty because we’re not getting the help like convicted people are.” (Study Participant B)

Of the 12 remand prisoners interviewed, 11 confirmed that they were under the influence of alcohol at the time of their offence, with some admitting that if they hadn’t been drinking they would not have carried out the offence.

How well do you consider that these pressures have been responded to?
There is a growing awareness of the particular needs of remand prisoners and alcohol related harm. Seven years ago, a report of Prisoner Health Needs Assessment for Alcohol Problems was published with a range of comprehensive recommendations for both sentenced and remand prisoners [5]. Despite this, it would appear that little has changed ‘on the ground’ since then. Universal screening with a validated tool such as AUDIT alongside delivery of appropriate and relevant alcohol interventions developed specifically for this setting and population are not evident. IT systems to record this type of activity linked to the community setting do not exist, making it difficult to follow up those on liberation and evaluate effectiveness. Little investment has been made in fully exploring the effectiveness of interventions of this nature in the prison setting, despite 20% of the Alcohol Brief Interventions (ABIs) H4 Heat Standard delivery to take place in ‘wider settings’ such as prisons.

“I think they’re just starting to...I mean, things obviously...regimes in here take a long time to get anything started. So I think, you know, in terms of like maybe about a year or two, it sounds like a long time, but in terms of changing prison policy, that’s nothing. You know, it could take up to five, six, seven years for things to actually get moving. So I think they’re just starting to get on the idea that alcohol is such a problem and something needs to be done about it, on the back of the government realising it and it being all over the news about the change in pricing policy and all this stuff. Finally, I think the prisons are starting to get an idea that it’s not just drugs that are the problem, that alcohol’s a big...is a bigger problem for a lot of people, if not worse.” (Study Participant C)
To what extent do you believe that health inequalities are/could be addressed in the prison healthcare system?

Prison offers an opportunity for the identification, response and/or referral to treatment for those male remand prisoners who are consuming alcohol above recommended levels. Most remands are very short in length of time with more serious offences being longer (the average length of time held in custody for those on remand is 9 weeks, although there are reports that there are increasing breaches of the 140 day rule). Therefore, access to ‘mainstream’ prison-based alcohol services such as alcohol screening, interventions, treatment and referral to additional services is very often not possible. This is the challenge, but one that is possible to address with commitment and structures in place to support through care that incorporates housing, employment and long standing social problems within alcohol support.

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

Many remand prisoners suffer from a poorer regime, have little awareness of support services available in prison. Induction often covers just the basic information relating to rules and regime, with information provided considered as too much at a highly emotional and charged time [6]. In addition, through care and resettlement support is difficult due to uncertainty with release dates. Many remand prisoners live in unstable accommodation before entry into the criminal justice system and once remanded into custody will lose this and subsequently have nowhere to live on release. Even when remand prisoners engage with services in prison, our interviews with stakeholders identified that connecting with remand prisoners following liberation is very challenging e.g. if remand prisoners are released straight from court, they will often not return to prison to collect their belongings and phone (the only method of contact if someone is homeless and doesn’t have a GP).

Trust and mistrust in staff was a major theme identified in the interviews we carried out.

“I wouldn’t go to a member of staff... Like fair enough a nurse can do it as well but I don’t really know. I just look at them all being, not in a bad way, like the same, it’s like somebody from the outside that’s going to be a wee bit more confidential.” (Study Participant F)

Regimes, structures and staffing levels within prisons often create barriers to services having access to remand prisoners.

Can you identify potential improvements to current services?

Screening to identify those with or at risk of alcohol problems and providing a short structured intervention to reduce drinking, has been shown to be effective in other settings, e.g. if remand prisoners are released straight from court, they will often not return to prison to collect their belongings and phone (the only method of contact if someone is homeless and doesn’t have a GP).

In our survey, forty-three percent of male remand prisoners with a positive AUDIT score said that 5 minutes of advice on reducing their drinking would ‘Not be useful at all’ with 19% identifying that it would be ‘Extremely useful’. However, when asked how useful 20 minutes of counselling would be, there was a reduction to 24% of those who said it would ‘Not be useful at all’. Meanwhile there was an increase to 37% of those identifying that it would be ‘Extremely useful’. Remand prisoners consistently identified that they would want more than one session focused on alcohol support. Many also identified the challenges of life outside prison and the need to have ongoing support to help them with alcohol-related harm. This level of support is currently not available or being accessed.

“I would need a follow up when I was outside, like, because being in here and saying one thing is – when you are outside it’s a totally different thing, do you know what I mean.” (Study Participant D)
Maximising existing resources and clinical staff to provide entry level alcohol related engagement with referral onto specialist services where necessary is fundamental and possible.

What do you think the main pressures will be in the next 15 years?
Workforce planning for health and social care staffing in prisons. In addition, we have an ageing nursing workforce. If we consider the opportunity of nurse-led services to provide large proportion of health care and public health interventions within prisons we will need a strong supply of nurses who want to work in the criminal justice setting (health and well-being), who are clinically competent to do so (time to produce staff at this level).

Ageing prison population, increase in long-term conditions, mental well being and non-communicable disease. Health inequalities and associated impact on remand prisoners.

References


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