Thank you for the opportunity to provide the views of the Scottish Prison Service (SPS) in relation to your Committee’s inquiry into prisoner healthcare. I have confined myself in this letter to a high level response to the specific topics that you have raised. Naturally, I will be very happy to provide further information and comment when I appear before the committee on 28 March 2017.

**Current pressures on health and social care provision**

A key driver behind the transfer of healthcare services from SPS to the NHS was the health inequalities faced by the prison population. Despite the efforts of NHS colleagues and numerous partner agencies, including ourselves, many of these inequalities still exist 5 years on.

As I am sure you will be aware, the demographics of our prison population are changing. We now have an increasing number of older prisoners entering custody, in part as a consequence of prosecutions for historic offending. Even Scotland’s most modern prisons, which have been designed with specially adapted cells to accommodate those with disabilities or acute physical needs, do not have the number of such cells that are now required. Of course, an aging population brings with it an increasing number of health and social care challenges, including the need to consider palliative care. It is worth highlighting that SPS research has uncovered that social care needs are not restricted to the older generations. 40% of those identified in our recent social care needs assessment as likely to benefit from social care/reablement support were under 50. In some cases these needs are intensified by the consequences of chaotic lifestyles led whilst in the community.

As has been reflected in a variety of reports by Her Majesty’s Inspectorate of Prisons for Scotland (HMIPS), there are a significant number of people in custody with acute mental health problems. Accessing services to support these mental health needs has proven to be problematic and a more holistic approach to addressing this issue is needed.

Different organisational priorities, practices and processes adopted by individual health boards mean that there is not a universally consistent approach in prisons to a range of medical practices e.g. prescribing regimes and service provision.

A more recent development has been the emergence of New Psychoactive Substances (NPS). The use of these substances can have serious short-term and long-term effects. They present a real challenge both in terms of the provision of care for those using the substances, and to SPS in the detection and prevention of their introduction to the custodial estate. Individuals using such substances also present significant risk to themselves, to staff and other people in custody.

**Current barriers to improving health outcomes and areas for potential improvement**

It is hard to establish the effect of the transfer of prison healthcare on health inequalities, and to share good practice, due to the lack of consistent health management information or national prison healthcare standards. SPS would welcome the implementation of national standards and management information reporting as the lack of such standards has meant that it has been hard to gather meaningful performance data to monitor outcomes for those in custody.
A greater degree of strategic oversight on the delivery of health and social care across the prison estate, which includes the involvement of service users, would, in our view, drive improvement and best practice in the delivery of healthcare across the whole of Scotland.

SPS would welcome the development of national standards and performance measures for mental health and substance misuse services to help drive best practice. Waiting time targets for access to drug and alcohol services apply in prisons, however the targets for access to psychological therapies do not.

Whilst we have a clear Memorandum of Understanding with the NHS which sets out the roles and responsibilities in relation to the provision of healthcare, no such arrangement is in place with regard to the provision of social care. SPS would welcome clarity on this issue which would in turn address areas of current concern including access to appropriate aids, adaptions and support for those with social care needs, and provide clear lines of responsibility for arranging and carrying out single shared assessments.

One of the original objectives of the transfer of prison healthcare to the NHS was to ensure a seamless transition back into the community, so that the health care services provided in prison could be continued and that, as had often been the case, those being released from custody did not drop off the ‘care radar’. SPS’ Throughcare Support Officers have identified a number of opportunities for improvement and ways in which they could support this process during the early stages of transition from custody to the community.

SPS believe that the time in custody can offer an excellent opportunity to address a range of health inequalities. It is a prime opportunity not just for health intervention through specific services but for influencing the wider factors in a person’ life that can affect their health and wellbeing. Addressing health inequalities experienced by people in prison can lead to a ripple effect with the potential to improve not just their life chances but those of their family and wider social circle.

Yours sincerely,

Teresa Medhurst
Director of Strategy & Innovation