The Committee will meet at 10.15 am in the James Clerk Maxwell Room (CR4).

1. **Subordinate legislation:** The Committee will consider the following negative instruments—

   The National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2017 (SSI 2017/27)
   The National Health Service Pension Scheme (Scotland) (Miscellaneous Amendments) Regulations 2017 (SSI 2017/28)

2. **Healthcare in Prisons:** The Committee will take evidence from—

   Alison Douglas, Chief Executive, Alcohol Focus Scotland;

   Professor Aisha Holloway, Professor of Nursing Studies, The University of Edinburgh;

   Theresa Fyffe, Director, Royal College of Nursing Scotland;

   Yvonne Robson, Partnership Manager, Shine Women's Mentoring Service, Representative for the Scottish Association for the Care and Resettlement of Offenders;

   David Liddell, Chief Executive Officer, Scottish Drugs Forum;

   Sandra Campbell, Macmillan Nurse Consultant for Cancer & Palliative Care, Representative for the Scottish Partnership for Palliative Care;

   Paul Noyes, Social Work Officer, Mental Welfare Commission for Scotland.

3. **Healthcare in Prisons:** The Committee will discuss the recent informal evidence sessions.
4. **Healthcare in Prisons (in private):** The Committee will consider the main themes arising from the oral evidence heard earlier in the meeting.

5. **Work programme (in private):** The Committee will consider revised draft correspondence.

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Edinburgh  
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The papers for this meeting are as follows—

**Agenda item 1**

Note by the clerk  
HS/S5/17/7/1

**Agenda item 2**

PRIVATE PAPER  
HS/S5/17/7/2 (P)

Healthcare in Prisons submissions  
HS/S5/17/7/3

**Agenda item 5**

PRIVATE PAPER  
HS/S5/17/7/4 (P)
Overview of instruments

1. There are two negative instrument for consideration at today’s meeting:
   - The National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2017 (SSI 2017/27)
   - The National Health Service Pension Scheme (Scotland) (Miscellaneous Amendments) Regulations 2017 (SSI 2017/28)

The National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2017 (SSI 2017/27)

Background

The National Health Service Superannuation Scheme (Scotland) Regulations 2011 (1995 Section) and the National Health Service Superannuation Scheme (2008 Section) (Scotland) Regulations 2013 require members of the NHS Superannuation Scheme (NHSSS) to pay contributions to the Scheme as a condition of membership. This instrument makes changes to the salary/earnings bands of the table in these regulations against which the employee contribution is set. Employees who are members of the scheme pay a percentage of their pensionable pay to the scheme dependent on the level of their pensionable earnings. It was agreed during scheme reform discussions the employee contribution percentage rates for period 1 April 2015 to 31 March 2019 would not change however the pay/earnings bands against which the contribution is assessed would be adjusted each year in line with national NHS pay awards in Scotland. The aim is to ensure that the bandings remain in line with annual increases in members pay. This SSI will therefore insert into the Regulations a revised employee contribution table to reflect the pay uplift from 1 April 2016 and which will apply to majority of members from 1 April 2017. The revised table will however be applicable with retrospective effect from 1 April 2016 for officer members changing employment within the scheme year 2016/2017, new starters, practitioners and non GP partners whose contributions which are based on current year income. The Policy note from the instrument is attached at Annexe A.


3. There has been no motion to annul this instrument.

4. The Committee needs to report by 20 March 2017.
Delegated Powers and Law Reform Committee consideration

5. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 21 February 2017. The Committee determined that it needed to draw the attention of the Parliament to this instrument on the following grounds:

6. The Delegated Powers and Law Reform Committee draws the Regulations to the attention of the Parliament on reporting ground (i), as regulation 1(2) appears to be defectively drafted. In accordance with the Scottish Government’s intention, regulation 1(2) should have provided that regulations 31 and 40 have retrospective effect as from 6th April 2016, rather than coming into force on 13th March 2017.

7. The Delegated Powers and Law Reform Committee however welcomes that the Scottish Government has undertaken to make the necessary amendment to provide for that retrospective effect, when the National Health Service Superannuation Scheme (2008 Section) (Scotland) Regulations 2013 (S.S.I 2013/174) are next amended.

The National Health Service Pension Scheme (Scotland) (Miscellaneous Amendments) Regulations 2017 (SSI 2017/28)

Background

The National Health Service Pension Scheme (Scotland) Regulations 2015 (“the 2015 Regulations”) require that members of the NHS Pension Scheme pay contributions to the Scheme as a condition of membership.

This instrument makes changes to the salary/earnings bands of the employee contribution tables in these Regulations. It was agreed during scheme reform discussions the employee contribution rates for period 1 April 2015 to 31 March 2019 would not change however this was on the basis that the pay/earnings bands set out in each tier would increase each year in line with national NHS pay awards in Scotland. The aim is to ensure that the tiering remains in line with annual increases in members pay. This SSI will therefore insert into the Regulations a revised employee contribution table to reflect the pay uplift from 1 April 2016. The revised table will be applicable with retrospective effect from 1 April 2016 for officer members changing employment within the scheme year 2016/2017, new starters, practitioners and non GP partners whose contributions which are based on current year income. For all other members the revised bandings will be applied from 1 April 2017. The Policy note from the instrument is attached at Annexe B.

8. An electronic copy of the instrument is available at:


9. There has been no motion to annul this instrument.

Delegated Powers and Law Reform Committee consideration

11. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 21 February 2017. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.
POLICY NOTE

THE NATIONAL HEALTH SERVICE SUPERANNUATION SCHEME
(MISCELLANEOUS AMENDMENTS) (SCOTLAND) REGULATIONS 2017 (SSI 2017/27)

The above instrument was made in exercise of the powers conferred by sections 10 and 12 and schedule 3 of the Superannuation Act 1972. Functions under that Act as regards Scotland have been executively devolved to the Scottish Ministers. The instrument is subject to negative procedure.

Policy Objectives

Amendments to the National Health Service Superannuation Scheme (Scotland) Regulations 2011 (SSI 2011/117) and the National Health Service Superannuation Scheme (2008 Section) (Scotland) Regulations 2013(SSI 2013/174)

Employee Contributions

The National Health Service Superannuation Scheme (Scotland) Regulations 2011 (1995 Section) and the National Health Service Superannuation Scheme (2008 Section) (Scotland) Regulations 2013 require members of the NHS Superannuation Scheme (NHSSS) to pay contributions to the Scheme as a condition of membership. This instrument makes changes to the salary/earnings bands of the table in these regulations against which the employee contribution is set. Employees who are members of the scheme pay a percentage of their pensionable pay to the scheme dependent on the level of their pensionable earnings. It was agreed during scheme reform discussions the employee contribution percentage rates for period 1 April 2015 to 31 March 2019 would not change however the pay/earnings bands against which the contribution is assessed would be adjusted each year in line with national NHS pay awards in Scotland. The aim is to ensure that the bandings remain in line with annual increases in members pay. This SSI will therefore insert into the Regulations a revised employee contribution table to reflect the pay uplift from 1 April 2016 and which will apply to majority of members from 1 April 2017. The revised table will however be applicable with retrospective effect from 1 April 2016 for officer members changing employment within the scheme year 2016/2017, new starters, practitioners and non GP partners whose contributions which are based on current year income.

Other main amendments

The following amendments are also made to the 1995 and 2008 sections of the scheme regulations:

• consequential amendments in respect of the abolition of contracting out, increase in the guaranteed minimum pension and enabling the forfeiture of a spouse’s or surviving civil partner’s guaranteed minimum pension and where the beneficiary is convicted of murder or culpable homicide

• conversion of pension into lump sum allowed where the sums involved are trivial
references updated in respect of “shared paternity leave” and the Pension Schemes Act 1993 and insertion of a cross-reference to the Public Service Pensions Act (Northern Ireland) 2014 1995 section only amendments
to clarify administrative procedures in respect of opting out
Makes an amendment to make clear that any buy-out policy purchased must satisfy the requirements of regulation 12(2) of the Occupational Pension Schemes (Transfer Values) Regulations 1996.

2008 section only amendments
Covers the ban on the transfer of deferred benefits from unfunded public service pension schemes to schemes offering flexible benefits by closing an existing lacuna in the provisions of the scheme regulations

The National Health Service (Scotland) (Injury Benefits) Regulations 1998
Amendments are made to the Injury Benefit Regulations to ensure that a person in receipt of permanent injury benefit under the Regulations who was in receipt of certain social security benefits which were replaced by the social security benefit known as “employment support allowance”, is not detrimentally affected by that replacement where the amount of employment and support allowance is greater than the amount of replaced social security benefits the member was receiving.

The National Health Service Superannuation Scheme (Scotland) (Additional Voluntary Contributions) Regulations 1998
Amendments are made to the AVC Regulations to enable a member’s money purchase additional voluntary contribution pension pot to be taken as a lifetime allowance excess lump sum.

Consultation
To comply with the requirements of section 10(4) of the Superannuation Act 1972 a formal policy consultation took place from 8 September 2016 to 19 October 2016. In particular, representatives of NHS employers and employees, other Scottish Government interests and UK Government departments were consulted. No responses to the consultation were received.

Impact Assessments
An equality impact statement in respect of the NHS Pension Scheme (Scotland) reforms (including contribution rates) was prepared and is available at http://www.gov.scot/Publications/2015/03/2855

Financial Effects
The increase in pay bands on which contributions for members are based is beneficial to members

Business and Regulatory Impact Assessment
No Business and Regulatory Impact Assessment is necessary as the instrument has no financial effects on the Scottish Government, local government or business.

Scottish Public Pensions Agency
An Agency of the Scottish Government
10 January 2017
The above instrument was made in the exercise of powers conferred by section 1(1) and (2) (e) and paragraph 5(b) of schedule 2 of the Public Service Pensions Act 2013 (“the Act”).

The instrument is subject to negative procedure.

**Policy Objectives**

Amendments to the National Health Service Pension Scheme (Scotland) regulations 2015 (SSI 2015/94)

**Employee Contributions**

The National Health Service Pension Scheme (Scotland) Regulations 2015 (“the 2015 Regulations”) require that members of the NHS Pension Scheme pay contributions to the Scheme as a condition of membership.

This instrument makes changes to the salary/earnings bands of the employee contribution tables in these Regulations. It was agreed during scheme reform discussions the employee contribution rates for period 1 April 2015 to 31 March 2019 would not change however this was on the basis that the pay/earnings bands set out in each tier would increase each year in line with national NHS pay awards in Scotland. The aim is to ensure that the tiering remains in line with annual increases in members pay. This SSI will therefore insert into the Regulations a revised employee contribution table to reflect the pay uplift from 1 April 2016. The revised table will be applicable with retrospective effect from 1 April 2016 for officer members changing employment within the scheme year 2016/2017, new starters, practitioners and non GP partners whose contributions which are based on current year income. For all other members the revised bandings will be applied from 1 April 2017.

**Additional Information**

In terms of section 22 of the Act, the Scottish Ministers are required to provide a report to the Parliament where they propose to make regulations changing (prior to 31st March 2040) a protected element of the scheme. Section 22(5) of the Act lists members’ contribution rates as one of the “protected elements”. This report was laid before the Scottish Parliament on 21 December 2016.

**Other Amendments to 2015 Regulations**

Amendments are made:

- as a consequence of the abolition of contracting out and increase in the guaranteed minimum pension
- to enable the forfeiture of a spouse’s or surviving civil partner’s guaranteed minimum pension where the beneficiary is convicted of murder or culpable homicide
• to allow conversion of pension into lump sum where the sums involved are trivial.
• to update references to the Pension Schemes Act 1993
• to reflect shared parental leave.
• to amend the provisions relating to pensions for a surviving spouse or surviving civil partner
• to amend the provisions relating to the amount of child pension so as to exclude from its calculation any upper tier ill-health pension
• to amend the provisions relating to opting-out and re-joining the scheme so as to enable a person with two employments to opt out of one but continue as an active member of the scheme in respect of the other Amendments to the National Health Service Pension Scheme (Transitional and Consequential Provisions) (Scotland) Regulations 2015

Amendments are made to:
• insert a new regulation 10A to deal with the effect of recommencing pensionable service following a break in employment and its effect on the calculation of, where appropriate, an ill-health pension or a death in service benefit
• make a technical amendment to the lifetime allowance condition so that it mirrors the provisions of the 2015 Regulations
• amend the table in regulation 38 to ensure that the correct proportion of a child’s pension is payable in the event of the death of a transitional member within 12 months of deferment of his pension

Consultation
To comply with the requirements of the Act, a formal policy consultation took place from 8 September 2016 to 19 October 2016. In particular, representatives of NHS employers and employees, other Scottish Government interests and UK Government departments were consulted. No responses to the consultation were received.

Impact Assessments
An equality impact statement in respect of the NHS Pension Scheme (Scotland) reforms was prepared and is available at http://www.gov.scot/Publications/2015/03/2855

Financial Effects
The increase in pay bands on which contributions for members are based is beneficial to members.

Business and Regulatory Impact Assessment
No Business and Regulatory Impact Assessment is necessary as the instrument has no financial effects on the Scottish Government, local government or business.
Alcohol Focus Scotland

Alcohol Focus Scotland is the national charity working to prevent and reduce alcohol harm. We aim to reduce the impact of alcohol in Scotland through the implementation of effective alcohol control policies and legislation. AFS welcomes the opportunity to provide written evidence to the Health and Sport Committee on the inquiry into healthcare in prisons.

Summary of key points

- Alcohol related crime is estimated to cost Scotland £727 million each year.
- 41% of prisoners report being drunk at the time of their offence, rising to 60% of young offenders.
- 73% of male prisoners have an Alcohol Use Disorder, with 36% possibly dependent.
- For those who have been imprisoned in Scotland, the risk of dying an alcohol-related death is three times higher for men and nine times higher for women.
- It is estimated the treatment gap for prisoners with alcohol problems is around 1:5, compared to 1:4 for people in the community.
- The number of alcohol brief interventions delivered in prison reduced from over 2,000 in 2014/15 to just over 1,000 in 2015/16.
- Tackling alcohol problems through the prison healthcare system has the potential to both reduce health inequalities and re-offending.
- It is also an opportunity to intervene and reach those who are ‘hard to reach’.

Pressures on health and social care provision in prisons

There is a strong link between alcohol and crime, particularly violent crime. Alcohol related crime is estimated to cost Scotland £727 million each year. Two in five (41% of) prisoners report being drunk at the time of their offence, rising to 60% of young offenders. Alcohol is implicated in 38% of those accused of homicide and 54% of victims of violent crime thought the offender was under the influence of alcohol. Not all alcohol problems in prisoners are linked to their offence. Between 18-34% of those in police custody have alcohol problems (mostly at the dependency end of the spectrum), and nearly three quarters (73%) of male prisoners have an Alcohol Use Disorder with 36% possibly dependent. Clearly the prison and custody populations are those with a high prevalence of alcohol problems.

Alcohol problems are often present with other co-morbidities including drug misuse and mental health problems. For example, there are strong links between alcohol misuse and depression, which is itself associated with violent crime; evidence suggests that depressed individuals are three times more likely to violently offend than the general population.

Alcohol misuse and harm is a current pressure on health and social care provision in prisons, and as such, it is essential that opportunities for intervention and treatment are optimised within the prison healthcare system.

Health inequalities in the prison healthcare system

The prison and police custody populations are predominately young, male and from deprived backgrounds, and there is a high prevalence of social exclusion factors. For those who have been imprisoned in Scotland, the risk of dying an alcohol-related death is three times higher for men and nine times higher for women.
Inequalities in alcohol-related harm also persist. There is evidence of the ‘alcohol harm paradox’ in Scotland, an internationally recognised pattern whereby people in lower socio-economic groups experience greater levels of harm despite consuming less alcohol than those in higher groups. \(^{10}\) People in higher socio-economic groups are more likely than those in lower socio-economic groups to consume above the recommended limit of 14 units per week. However, when looking only at those drinking above the recommended 14 units a week, men in the lowest socio-economic group consume considerably more than those in the highest.

In other words, although a smaller proportion of men in the lowest socio-economic group drink above recommended levels, those who do drink above those levels consume considerably more alcohol than those in higher groups. \(^{11}\) As a consequence those in our most deprived communities are eight times more likely to die or be admitted to hospital due to alcohol use than those in our more affluent communities. \(^{12}\)

Tackling alcohol problems through the prison healthcare system has the potential to both reduce health inequalities and re-offending, and to prevent the revolving door between prison and the community for too many individuals in Scotland. It is also an opportunity to intervene and reach those who are ‘hard to reach’, for example, because they are not registered with a GP or do not use mainstream health services. \(^{13}\)

Barriers to improving the health outcomes of prisoners

Although prisoners who have received treatment for alcohol report finding this useful (94% in the Scottish Prison Service 2015 prisoner survey)\(^ {14}\), challenges persist in the detection, recording and treatment of alcohol problems among prisoners. It is a concern that the proportion of prisoners assessed for alcohol use on their admission to prison sits at only 27% (an 11 percent decrease in the last five years). Few prisoners also report being given the chance to receive treatment for alcohol problems during their sentence, or receiving help or treatment during their sentence (25% and 14% respectively), again significant decreases from 39% and 24% in 2012. Even when help is offered for alcohol problems, many prisoners may be reluctant to take it: less than two fifths of prisoners agreed that they would accept help if offered.

We refer the Committee to the alcohol-specific recommendations within the National Prisoner Healthcare Network (NPHN) Guidance, particularly that “prisoners should have access to the same range of interventions (as non-prisoners in an NHS Board area) to facilitate recovery”. Successful implementation of these recommendations would go some way towards addressing the wider gap the NPHN identified for treatment of alcohol problems amongst people in prisons of 1:5, compared to people in the community of 1:4. The NHPN also recommended that: “Alcohol Brief Interventions (ABIs) should be available to prisoners from reception and throughout their stay in the prison setting”. Despite this, there has been a reduction in the number of Alcohol Brief Interventions carried out in prisons since the Guidance was issued: from over 2,000 in 2014/15 to just over 1,000 in 2015/16. \(^ {16}\)

Another challenge, also reflected in the NPHN Guidance, is to ensure that the necessary data is recorded and shared. For example, the Scottish Government should consider monitoring the success of ABI delivery in reducing the consumption of those who receive them. This highlights the significant role that prison through care plays in monitoring outcomes in this area.
Main pressures for the future

Although consumption rates have fallen since 2009, the most recent data suggest that the amount of alcohol sold has increased since 2012, and rates of alcohol-related hospitalisations and deaths continue to be higher than in the 1980s. If this marks the start of a longer-term trend, it would be expected that levels of alcohol harm would rise, across the whole population and within prisons. This may apply additional pressure on an already overburdened healthcare system in dealing with the needs of a population in which alcohol harm is already particularly prevalent.

6 MacAskill, S. et al. (2011), Assessment of alcohol problems using AUDIT in a prison setting: more than an aye or no question, BMC Public Health, 11:865.
9 MacAskill et al. (2011) op cit.
11 ScotCen analysis of the 2015 Scottish Health Survey, as discussed at https://t.co/uXWkseNxSB;
16 Byrne et al. (2016) op cit. p.35.
17 Unpublished data, Information Services Division (ISD), NHS Scotland.
The Health and Sport Committee has launched an Inquiry into Healthcare in Prisons and ‘Called for Views’ (03.02.17) from any interested organisations or individuals.

The Mental Welfare Commission for Scotland visit Scottish Prisons regularly as part of our visiting programme. The fact that prisoners have a much higher rate of mental disorder than the general population has been well documented and this is the reason for our visits to prisons; we look at mental health services being provided to prisoners and ask prisoners about their experience of using these services.

The Commission’s responses to the Health and Sport Committee are limited to our views on prisoner mental health care (only) in prisons.

The call for views seeks input on the following four questions:

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

  **MWC Response:**

  In relation to mental health provision the Commission would support the RCN findings that there is a considerable variation across prisons and health boards in relation to mental health care available to prisoners. During our prison visits we have found:

  - Prisons across Scotland appear to have variable levels of staffing dedicated directly to mental health provision.
  
  - In some areas mental health nurses time is also spent in dispensing medication which takes time from mental health provision.
  
  - In some prisons mental health nurses’ are involved in reception interviews to screen for mental health difficulties. If mental health needs, particularly for remand prisoners or people starting sentences, are not identified at reception this can have a significant impact on a prisoner’s mental health. Information is rarely passed on to prisons from the community teams proactively.
  
  - There is very variable expertise in relation to Learning Disability and patchy use of screening tools. There are particular difficulties in the prison system in distinguishing between learning difficulties and learning disabilities. Often due to their chaotic lifestyles, many prisoners have missed out on school and education and have profound learning needs. The needs of these individuals are often very different to those prisoners with learning disabilities who regularly tend to commit minor offences and be in prison for very short periods of time but require specialist intervention. These factors combine to make the process of screening and identifying prisoners with a learning disability a difficult process.
- The referral process is very different across different prisons with mental health drop-ins operating on the halls in some prisons and paper referral systems operating in others.

- Some prisons have very good interviewing facilities and health centres; others have facilities that are very poor.

- The level of skill and training for prison officers in mental health issues in different prisons is variable.

- Advocacy services are variable across different prisons in terms of both provision and awareness of services.

- Relationships between health centre staff and prison officers are vital in being able to arrange interviews and access visiting services. We have found these relationships again to be variable in different units.

- A big and ongoing issue is access to input from psychology and also access to lower level psychological interventions, therapies and support for trauma.

- The lack of the use of care plans in patient notes for prisoners with complex care needs is a recurring recommendation from our visits. Prisoners can be seen by a range of services such as nurses, psychology, additions nurses, psychiatrist and other agencies. For such individuals a formalised care plan is required to ensure a consistent approach and a clear understanding or the prisoner's needs and goals.

- The Mental Welfare Commission’s report Mental Health of Women Detained by the Criminal Courts - In Prison and Hospital Settings (2014) highlights specific issues faced by women prisoners. Most of these women had experienced physical and sexual abuse, had current substance abuse problems and most acknowledged they had previously had mental health difficulties. This report also highlighted the need to develop focused and effective therapeutic interventions for women in prison with borderline personality disorder and post-traumatic stress disorder.

- The lack of high security mental health provision for women in Scotland has also caused difficulties from time to time; Scottish Government are keeping this situation under review.

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

**MWC Response:**

- Some health boards are beginning to address the access to psychology issue and Greater Glasgow and Clyde have recruited new psychology posts between Barlinnie, Low Moss and Greenock prisons which is a good development.

- Progress towards any form of service mapping or identification of gaps in services seems to have been very limited. Service development is likely to be
very much constrained by resources available and probably reflects a long-term underfunding of these services.

- We have noted on some recent visits that the transfer of responsibility of prison health services to health boards has enabled better access to health information from the community due to shared computer systems.

- We have heard from nurses working in the prison setting that they now have better access to training provided by health boards and they also have more identity with the NHS.

- The Commission continues to promote the expectation that prisoners should have access to a full range of full multi-disciplinary services to promote their mental health. Our experience is that there is little coordinated input to mental health care of prisoners beyond the input of mental health nurses and psychiatrists, despite cases being discussed in a multi-disciplinary forum.

- The Mental Welfare Commission Report ‘Mental Health of Prisoners’ (2011) set out key messages for prisoner mental healthcare. Despite having been adopted by the National Prisoner Healthcare Network it is now 6 years since this Commission report and in terms of prisoner’s experience of care, not much has really changed. Progressing the recommendations of the report appears to be very slow and an audit of the current provision against these recommendations is needed.

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

  **MWC Response:**

  - We would expect prisoners to have good access to mental health care when in prison particularly as it is well known that the level of need in this population is higher than that in the community. There are potential opportunities to engage with prisoners during their time in prison to address issues that may be contributing to their offending that should not be missed through lack of resources. It is however very important that services are available in the community to reduce the chances of individuals with mental health difficulties coming to prison as this is not a therapeutic environment for care and treatment.

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

  **Response:** No specific comments to make.

- **Can you identify potential improvements to current services?**

  **MWC Response:**

  - There needs to be a clear strategic plan in relation to what Health Boards should be providing in prisons.
  - A major barrier to improving services is the lack of additional resources.
What do you think the main pressures will be in the next 15 years?

MWC Response:
- It is likely that demands on services will continue and increase as will pressure on the resources available.
Background

In November 2016, RCN Scotland published a report ‘Five Years On’ which evaluated how far the aspirations behind the 2011 transfer of prison healthcare from the Scottish Prison Service (SPS) to NHS Scotland are being put into practice.

The report concluded that there is not enough evidence to fully assess the impact that the transfer has made on meeting the needs, and tackling the health inequalities of people in Scotland’s prisons. RCN Scotland found that the picture across prisons and health boards was extremely mixed. Whilst the RCN found examples of good practice and innovation in some areas, there were also numerous examples of where core healthcare services are falling short.

Overall, the RCN concluded that the transfer was the right thing to do, but shared the frustration of many of those trying to access and provide services, who felt that progress was slow.

‘Five Years On’ showed that there is significant work to do to ensure that the aspirations of the prison transfer from SPS to NHS Scotland are translated into services which demonstrate consistency and equity, and which deliver improved health outcomes for people in Scotland’s prisons.

RCN Scotland carried out a survey of nursing staff in prisons ahead of the transfer in 2011 and repeated some of the questions in its 2016 survey. All survey statistics relate to the 2016 survey unless stated otherwise.

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

Not unlike other services within Scotland’s NHS, budget and workforce were seen as the main pressure points in terms of delivering healthcare in prisons. The demand for services in prisons outstrips the resources available to fund and deliver care.

The money transferred to health boards was based on historic spend by the SPS on healthcare. In June 2012 the Scottish Government reviewed the baseline budget for prisoner healthcare across NHS boards through the Prisoner Healthcare Post-transfer Financial Review and concluded that funding ‘appears adequate at national level to support provision of existing services previously provided by SPS’. The problem with this Review is that it looked exclusively at the provision of existing services, and failed to consider the services which were needed to reduce health inequalities, as well as to bring patient care in line with the care that others receive in the community. During the Review process health boards did raise concerns around the future pressures to provide services.

Throughout RCN Scotland’s research for ‘Five Years On’, resourcing was raised consistently as a challenge. There was a shared feeling that NHS boards failed to recognise the disproportionate level of need required by people in prisons. There were particular concerns around some services, like mental health, where only 49% of respondents to the RCN’s nursing survey of those working in prisons, felt that the mental healthcare needs of people in prison were being met.

Staffing is also a very real pressure in delivering adequate healthcare in Scotland’s prisons. The vast majority (84%) of nursing staff working in prisons and surveyed by the RCN said that inadequate nurse staffing levels are a barrier to providing care. Some staff reported that they felt that they were constantly ‘fire-fighting’. What the RCN discovered in its research was that as soon as a nursing team is short-staffed, priority is given to medications management. This means that other services, like long-term condition clinics and follow-up services, are reduced. Inspections have also found that in some prisons mental health and addiction nurses do not have protected time to carry out their role, and are also required to carry out general nursing roles which detract from their specialism.
Nurses working in prisons also felt that access to the wider healthcare team is an issue. Of those nurses surveyed by the RCN, 75% said that staffing levels of other health professionals is an issue. Access to GPs is a particular problem. Staff numbers, long waiting times, a lack of continuity of staff and time pressures leading to short assessments were raised time and again in the course of the RCN’s research.

Meeting the complex health needs of a growing population of older people in prison is also a significant challenge. The number of people in prison over the age of 50 has, according to Scottish Government prison statistics, increased by 50% in the last five years and in 2013/14 around 10% of people in prison in Scotland were over 50. The higher age profile is due to increasingly lengthy sentences; historic cases being prosecuted and the overall increase in life expectancy.

For health services, this changing age demographic represents a disproportionate challenge because of the already complex nature of the health needs of many people in prison, and their general health status which is around that of someone 10 years older than them. In addition, 46% of people in prison over the age of 50 report having a long term condition and 37% report having a disability. The ageing profile of the prison population brings challenges around specialist areas like dementia care and end of life care.

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

The inadequacy of the funding, inherited from SPS, to deliver health services in prisons has not been addressed since the 2012 Prisoner Healthcare Post-transfer Financial Review concluded that it was adequate to support existing services.

What needs to be examined is not only the funding required to deliver current services, which will undoubtedly have changed, but also a clear idea of what additional services are required to actually meet the health needs of Scotland’s prison population. There are still gaps in the health intelligence about people in the criminal justice system, with things like the prevalence of long-term conditions, mental health and learning disabilities all being unclear. Part of the lack of clarity around need is due to a lack of robust data on the extent of the prison population’s health needs because of the way that information is recorded at present.

One of the drivers for the transfer of prison healthcare from SPS to NHS Scotland was a concern about the sustainability of the delivery model, and a recognition that as a small organisation SPS was limited in attracting the range of health expertise needed and that as part of the NHS prisons would have access to a wider cohort of clinical expertise and community based services to draw upon.

In spite of the hopes of the transfer, there are still significant concerns around the morale of the nursing workforce in prisons, which are underpinned by recruitment and retention issues, staffing pressures, and a lack of understanding from the wider NHS on the role of prison healthcare. A general feeling of being undervalued was evident amongst the prison nursing workforce, with 63% of respondents to the RCN survey stating that they felt neither a part of nor valued by their wider health board.

The RCN’s 2016 survey found that fewer nurses now feel that working in the criminal justice field is a rewarding career (90% in 2011 compared to 63% in 2016). Only 53% of the 2016 respondents feel satisfied in their current role, compared to 76% in 2011 and only 59% thought that they would be doing a similar criminal justice nursing role in two years, a stark comparison with the 90% of respondents who said that they would still be working in the field in 2011. One of the nurses surveyed by the RCN said “we were promised so much prior to transfer (improved banding, support etc.) and it didn’t transpire.”

It was clear in RCN’s research that morale of the nursing workforce varied widely across different prisons. Health centre managers were also found to be more positive about the transfer than frontline staff, whilst team leaders and clinical managers had mixed views. Frontline staff who felt positive about the transfer has generally had a higher level of support.
from their health board during the process, and they were also more likely to report that training, and practice and career development opportunities had increased since 2011.

Recruitment and retention was raised with the RCN consistently as an issue, with reported high staff turnover and sickness absence. 72% of nursing staff employed by SPS prior to the transfer said that they had seen an increase in sickness absence. The induction process for new staff was also observed to be less in depth than prior to transfer, which staff felt could account for some of the high turnover as new staff were not fully prepared for working in a custodial environment. Nurses often felt that they were becoming de-skilled because ‘key tasks’ such as medications management took priority over other services when services were short staffed. As with other areas of the NHS there were problems around staffing models not reflecting patient need, and the skill mix not being correct. At present there is no national nursing workforce planning tool specifically for prisons and managers have had to adapt tools, or mix tools.

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

A key driver for the transfer of prison healthcare to the NHS was to tackle the stark health inequalities faced by those in prison. To date, however, it is not possible to evidence the impact that the transfer has had on tackling health inequalities. This is because there are still knowledge gaps - both around the health inequalities faced by those in prison as well as their health needs – driven by the lack of a national reporting and quality outcomes data for prison healthcare.

One of the first steps towards addressing health inequalities experienced by those in prison is to develop and implement robust methodologies for capturing and reporting data about their healthcare needs at both local and national level. Reliable data could aid better resource allocation. Quality outcome indicators would contribute to forming a national picture of prison health which, as well as flagging areas for improvement, could highlight areas of good practice and opportunities for learning from it.

Whilst the RCN’s research highlighted some positive work that has taken place since transfer, there was a general feeling that progress was slow and that more could be done to address health inequalities in prison and through a continuity of care both in prison and when individuals are released.

In spite of the current lack of data, and the slow pace of change, the RCN and the criminal justice nursing workforce feel that the custodial environment offers a unique opportunity to address health inequalities and to ensure that these vulnerable people, with typically poor engagement with health services, get the health interventions and care which they require.

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

As well as challenges in relation to budgets, resources, and data collection there are issues around the clinical IT system, VISION, which is used in prisons not being fit for purpose.

Less than a third (31%) of nurses working in prisons who responded to the RCN survey said that they felt that healthcare in the criminal justice system was a priority for their board. As such, there is work to do to ensure that NHS boards prioritise the health needs of people in prison, affording them the same commitment to person centred care as people receive if they are in the community. This includes listening to what people in prison say about the services they require.

The lack of strategic leadership and a coordinated, overarching strategy at Government level was also raised as a barrier to improving the healthcare and health outcomes of those serving a custodial sentence.
In addition, the nature of the prison regime and the need for escorts means that there are limited opportunities for health professionals to see people in prison. Particular concerns were raised around the availability and willingness of G4S to take individuals to hospital appointments, with one nurse telling the RCN that ‘one patient had their appointment rescheduled four times due to G4S being a no show.” In some instances the prison environment itself was seen as a barrier because of a lack of facilities for those, for example, with high care needs.

Out of hours care is a big challenge: just over half of the respondents to the RCN survey of prison nurses felt that the health care needs of people in prison were being met at weekends and only 27% felt that health needs were met overnight. Two focus groups with people in prison raised concerns around accessing healthcare after 9pm, when they felt response times were slow and when they felt uncomfortable with a prison officer assessing whether to call a nurse or doctor.

Staffing pressures are one of the barriers to continuity of care because patients see multiple health staff. Building a therapeutic relationship between health practitioner and patient is crucial when dealing with vulnerable people and could help to improve the health outcomes of individuals in prison.

Overall, many of the challenges mean that individuals in the criminal justice system experience a lack of continuity of care which is unacceptable, and which does nothing to tackle health inequalities and health outcomes in the long term.

**Can you identify potential improvements to current services?**

There needs to be a strategic vision for the delivery of health services in prisons which is built on evidence of the health needs of those serving sentences. This requires investment in data collection so that benchmarking and monitoring can take place.

Staff pressures and low morale need to be addressed as a matter of urgency. Investment in staff numbers, staff training and CPD are first steps towards helping to ensure better outcomes for people in prison.

There also needs to be significant work done to improve the continuity of care which people receive both inside prison and upon release.

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

Budgets and staffing will continue to be sources of pressure over the next 15 years. If the challenges around continuity of care continue are not tackled and resolved then this will put increased pressure on both health services in prisons and in communities. In addition, the challenge of caring for older prisoners with increasingly complex care needs, such as dementia, will need to be addressed fully.
Scottish Drugs Forum, Hepatitis Scotland and HIV Scotland

- Scottish Drugs Forum is a membership based drugs policy and information service and is a national resource of expertise on drug issues.
- Hepatitis Scotland is the national voluntary sector organisation, funded by the Scottish Government and hosted within Scottish Drugs Forum, to help improve responses to viral hepatitis prevention, treatment and support.
- HIV Scotland is the national HIV policy organisation for Scotland, working on behalf of all those living with, and at risk of, HIV.

**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?

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

**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?**

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

**Operational management**

It is challenging to deliver person-centred health care within the constraints of a secure environment and the current operating procedures within Scottish prisons. Health staff in prisons spend large amounts of time supervising the dispensing and consumption of medication in prison and this can often amount to the entire workload of prison nurses. This is partly due to the security required to move prisoners around a prison to receive their medication.

Resolution should be made by senior management within prisons and health managers that

- operational issues around staffing and location should be resolved to allow nurses and healthcare staff more time with prisoners to address their health needs rather than spend a high proportion of their time dispensing medication.

Coordinated provision of health care is not solely an NHS responsibility. Prisons management priorities and local policies regarding prisoner health needs must be evidence based and supported across the entire prison estate.
Drug treatment

Other pressures are self-imposed including drug treatment regimes that would be regarded as poor practice in community services being adopted as standard within prisons including the refusal of drug treatment and non-optimal prescribing of medication to patients i.e. under-dosing – a potentially dangerous and wasteful practice.

- The new Drug Misuse and Dependence UK Guidelines on Clinical Management (The ‘Orange Guidelines’) are appropriate for Scottish prisons and should be adhered to as an model of good practice.

As far as treatment for drug problems is concerned the following principles should guide the development and delivery of treatment in prison settings

- A prison sentence should be viewed as an opportunity for people with drug problems to work with professionals to address their drug and other health issues and they should be encouraged to engage in treatment and accept support and to engage in treatment which can be continued in the community after liberation.

- People in prison should be afforded continuity of care from the community, particularly in relation to opiate replacement therapy. This means that a seamless transition to the same treatment in prison as in the community should be achieved.

Non-fatal overdose is a key indicator of later mortality and the most powerful predictor of non-fatal overdose appears to be past experience of overdose. Among those who had been incarcerated recently, the risk of overdose was almost four times greater for those who had also overdosed in the past. This finding and other literature suggests that previous overdose experience does not increase the perception of risk for subsequent overdose but rather increases risk. Kinner and colleagues’ finding that drug injection in prison was a risk factor for overdose on release is at odds with the view that reduced drug tolerance is the overriding risk factor. Non-fatal overdose may therefore be a key marker for an individual having significant risk behaviours and therefore at greater risk of fatal overdose.

Engaging and retaining people in high quality treatment that meets good practice guidelines should be the primary focus of service development. This is the basis of the prevention of criminal recidivism and further engagement with criminal justice, further problem drug use and unplanned engagement with health and other services and to reduce health inequalities generally and particularly in terms of the risk of premature death. The promotion of recovery and the prospect of stable lives away from involvement in crime and problem drug use and the avoidance of onward transmission of blood-borne viruses represent a significant opportunity for individuals, their families and wider community as well as a significant cost saving in terms of prevention. The prison should, for some people, be a key driver for promoting prevention.
Scottish Drugs Forum, Hepatitis Scotland and HIV Scotland

Blood borne Viruses

The lack of provision of injecting equipment provision in Scottish prisons remains an anomaly. It is difficult to justify this given the effort and investment in injecting equipment provision in the community. It is difficult to prove the exact timing of infection and therefore claims that prison transmission rates are very low should be treated with caution, as should the claim that injecting rates in prison are low ‘because we do not find injecting equipment’.

Blood-borne virus (hepatitis and HIV) testing is inconsistent and poorly managed overall in prisons. Some establishments still insist on accessing venal blood rather than using dry bloodspot testing. One consequence is that testing on admission / reception is far less likely as a nurse has to be available. As soon at the prisoner is admitted and inducted into prison gaining a blood sample becomes less likely as they then have to actively seek out a test.

Access to treatment for BBVs in prisons is not confidential and this discourages both testing and treatment. Efforts have been made to enhance access to treatment services however some issues with through-care have impacted on prisoners continuing care on release. Unplanned movement across the prison estate has also led to interruption of, or initiation of, treatment regimes.

Access to condoms and education around sexual health including HIV prevention appears to be very limited.

Death prevention

There are other areas of immediate concern which should be addressed in terms of prevention of deaths in custody. Current practice of overnight observation checks are not adequate in preventing overdose deaths.

- There should be improved practice in terms of observation of prisoner to prevent overdose
- There should be training for staff and the availability of naloxone on every landing and hall.

NHS staff are not present at night. The reported operational issues that people would make constant requests to see nursing staff through the night is an indicator of need, not necessarily a reason not to proceed. A need to improve sleep patterns also exists. These are an indicator of other issues in terms of mental health and prison regime more generally that should not be ignored.

- There should be due consideration regarding whether NHS cover is reintroduced overnight.

It is disappointing that prison supply of naloxone to prisoners on release remains at low levels. It is recommended that -

- All prisoners at risk of overdose, ie all prisoners with a history problem drug use whether they have been using or been in treatment while in prison, should be provided with a take home naloxone kit on liberation. Prisoner opt-outs on this should be a subject of concern and efforts should be made to reduce incidence of this.
Scottish Drugs Forum, Hepatitis Scotland and HIV Scotland

Throughcare

Prison throughcare is an essential service that can link care started into prison into ongoing community based care. It allows greater levels of engagement post release and is crucial for BBV healthcare to continue post liberation.

- Communication between prison based and community healthcare systems are assessed for effectiveness then regularly audited
- Peer support networks are made available in prison and on liberation to support reintegration into community i.e. Smart recovery, NA, ORT and me.
- All prisoners are assessed prior to liberation regarding potential drug related risk behaviours
- Support is in place for continuation or initiation on ORT at release. Individuals at risk of opiate overdose are referred to prison through-care services

Older drug users

The prison population is continuing to age, with this there are a substantial number of older people with a drug problem (overall over half of Scotland’s 61,500 problem drug users are 35 and over and this figure will continue to rise for many years to come). Prison Health care must adapt to the increasing demand for health care. Recent research undertaken by SDF have identified that older people with a drug problem have a health profile equivalent to people at least 15 years older than in the general population. Many of these individuals have multiple morbidities include mental health and a range of physical health conditions. There is therefore a need for health care to adapt over the coming years to this changing demographic.

PLEASE NOTE ALL REFERENCES FOR THE ABOVE EVIDENCE CAN BE SUPPLIED ON REQUEST
Scottish Parliament Health and Sport Committee
Inquiry into healthcare in prisons
March 2017

Background

As part of a programme of research on prisoner health, currently being conducted at The University of Edinburgh, I was invited in November 2016 to work with Professor Alex McMahon (Executive Nurse Director, Nursing, Midwifery and AHP’s, Executive Lead REAS and Prison Healthcare, NHS Lothian), Dr Juliet MacArthur (Chief Nurse Research & Development, NHS Lothian, Lecturer Clinical Academic Research, University of Edinburgh) and Tracey McKigen (General Manager, Royal Edinburgh and Associated Services, NHS Lothian), to explore the opportunity/prospect/option of a nurse led model with advanced Nurse practitioners within the prison setting in NHS Lothian. During our discussions we agreed that there was a need to understand better the health of the prison population in order to provide some baseline data, from which any recommendations could be made in relation to health care delivery and models of delivery.

Health Needs Assessment (HNA) is identified by the Health Development Agency (now National Institute for Health and Clinical Excellence [NICE]) as “a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities” (pg 3) Data gathered is used to plan services, address health inequalities, target service planning and resource allocation [1]. A Health Needs Assessment of Prison Health in Scotland was last conducted in 2007 [2]. A review of Health Care Needs of Prisoners in relation to Throughcare was published in 2014 [3].

In partnership with Professor McMahon, Dr MacArthur and their team, we have begun to undertake an exploratory Health Needs assessment at HMP Edinburgh (December 2016 – present). The purpose was to scope out and ascertain if it was possible to identify prisoner health priorities from existing data drawn from the current VISION system. The health needs assessment covered the period 1st January and 31st December 2016 and involved all male prisoners entering HMP Edinburgh (379) and all female prisoners transferred to HMP Edinburgh (48). This focused specifically on 3 specific elements:

i) Profile the prisoner population at HMP Edinburgh
ii) Gather reliable data to inform the profiling
iii) Identify and assess health conditions and determinant factors
I will provide a brief overview of our experiences of undertaking this small piece of work as they align to the questions asked by the Committee.

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

We know that a significant majority of the prison population has complex health needs that present at various stages and at different levels of severity. Prisoners are more likely to suffer from physical and mental ill health, alcohol and drug addiction, learning disability as well as a range of social care and justice issues. In addition, specific prisoner sub-populations e.g. women, remand, young offenders, older people and minority ethnic groups prisoner, have distinct health needs in comparison to the prison population as a whole. Together with the increase in New Psychoactive Substances (NPS) and chronic health conditions it is clear that understanding the health and social care needs in prisons in order to respond is essential. From the work undertaken for example, we know that there is a clear difference in the number of women reporting mental well-being illness and drug use behaviour in comparison to men. This has implications for the delivery of effective and appropriate prisoner health care [4].

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

If we use the example of mental well-being described above we can see that mental well-being disorders are being reported by both male and female prisoners on admission/transfer in to prison in NHS Lothian. This data is self-reported by the prisoner and entered on the IT system (Vision) by NHS staff. The system allows free text entry, where additional information regarding the nature, extent and impact of these associated mental well-being disorders can be recorded. However, it is not possible to run reports on the free text entry data. This makes it very challenging to gather the level of data to inform the profiling of the prisoner population whilst understanding their true needs and responding to them in an effective and responsive way. For example from the data we have drawn on from Vision, there was a high proportion of both males and females reporting as having ‘other physical health problems’ – however to identify the nature of these health problems, we would need to look at individual records and free text data to find out further information and details.

The free text data can be gathered but would require additional resources and be time and cost intensive.

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

A response to this is outside the scope of the work that we have been conducting.
• What are the current barriers to using the prison healthcare system/ improve the health outcomes of the prison population?

The current IT system operates in isolation from external health care facilities i.e. GP practices. The current Vision system in the prison holds data only for the individuals’ time in prison. If they have been in prison before and come back in the original Vision record is used. From anecdotal evidence, a low number of prisoners know who their GP is. Where a GP is known, they are asked to send a medical summary with the prisoner history, however this is only if they are on medications so it is not for all admissions and a medical summary is not always received.

• Can you identify potential improvements to current services?

From the experiences of undertaking this piece of work, which attempted to provide a profile of the prisoner population at HMP Edinburgh, through the gathering of reliable data in order to identify and assess health conditions and determinant factors, the ability to have IT systems that support data capture and reporting would facilitate a robust understanding of health need and in turn resource planning and allocation.

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

A response to this is outside the scope of the work that we have been conducting.

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References


1st March 2017
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 peole, 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, offering the potential of being suitable for prisoners. The World Health Organisation (WHO) proposes addressing alcohol harm in prisons can potentially reduce the risk of re-offending with health savings of £4.3m and crime savings of £100m per year possible as a result of appropriate alcohol interventions. Nevertheless, setting up systems and structures to support through care services with IT systems to support rigorous evaluations requires investment by Governments. Whilst this may not be seen as an ‘attractive’ use of resources amongst policy makers or the general public, we must look to the potential longer term gain and the opportunities and reduction in health illness that investment can bring.

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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