OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 14 March 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 14 March 2017

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HEALTH AND SPORT COMMITTEE
7th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sandra Campbell (Scottish Partnership for Palliative Care)
Alison Douglas (Alcohol Focus Scotland)
Theresa Fyffe (Royal College of Nursing Scotland)
Professor Aisha Holloway (University of Edinburgh)
David Liddell (Scottish Drugs Forum)
Paul Noyes (Mental Welfare Commission for Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 14 March 2017

[The Convener opened the meeting at 10:15]

Subordinate Legislation

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

The Convener (Neil Findlay): Good morning and welcome to the seventh meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to set their mobiles to silent, and I also remind all present that, although it is acceptable to use mobile devices for social media purposes in the room, photographs should not be taken and the proceedings should not be filmed.

Agenda item 1 is consideration of two Scottish statutory instruments that are subject to negative procedure. On the National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2017 (SSI 2017/27), no motion to annul has been lodged, but the Delegated Powers and Law Reform Committee has drawn the regulations to the Parliament's attention 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 from 6 April 2016, rather than coming into force on 13 March 2017. However, the Delegated Powers and Law Reform Committee welcomes the Scottish Government's undertaking to make the necessary amendment to provide for that retrospective effect when the National Health Service Superannuation Scheme (2008 Section) (Scotland) Regulations 2013 (SSI 2013/174) are next amended. Try saying all that without your false teeth in.

If members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

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

The Convener: No motion to annul the National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2017 (SSI 2017/28) has been lodged, and the Delegated Powers and Law Reform Committee has made no comments. If members, too, have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Healthcare in Prisons

10:17

The Convener: Agenda item 2 is our first evidence-taking session for our healthcare in prisons inquiry. As this is a round-table session, I first ask everyone around the table to introduce themselves briefly.

I am convener of the Health and Sport Committee.

Clare Haughey (Rutherglen) (SNP): I am the MSP for Rutherglen and the deputy convener of the committee.

Paul Noyes (Mental Welfare Commission for Scotland): I am from the Mental Welfare Commission for Scotland.

Tom Arthur (Renfrewshire South) (SNP): I am the MSP for Renfrewshire South.

Miles Briggs (Lothian) (Con): I am a Lothian MSP.

Sandra Campbell (Scottish Partnership for Palliative Care): I am a nurse consultant in cancer and palliative care, but today I am representing the Scottish Partnership for Palliative Care.

Donald Cameron (Highlands and Islands) (Con): I am a Highlands and Islands MSP.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am the MSP for Edinburgh Western and the health spokesperson for the Liberal Democrats.

Alison Douglas (Alcohol Focus Scotland): I am from Alcohol Focus Scotland.

Alison Johnstone (Lothian) (Green): I am a Lothian MSP.

Theresa Fyffe (Royal College of Nursing Scotland): I am the director of the Royal College of Nursing Scotland.

Richard Lyle (Uddingston and Bellshill) (SNP): I am the MSP for Uddingston and Bellshill.

Professor Aisha Holloway (University of Edinburgh): I am from the University of Edinburgh.

Maree Todd (Highlands and Islands) (SNP): I am a Highlands and Islands MSP.

David Liddell (Scottish Drugs Forum): I am from the Scottish Drugs Forum.

Colin Smyth (South Scotland) (Lab): I am a South Scotland MSP and the Labour spokesperson on public health and social care.

Ivan McKee (Glasgow Provan) (SNP): I am the MSP for Glasgow Provan.

The Convener: Thank you very much. I should say that we had also invited Sacro, but its witness cannot be here due to illness.

We will go straight to questions. Alex Cole-Hamilton will begin.

Alex Cole-Hamilton: Good morning, everyone, and thank you for joining us today.

I will start by asking panel members for their views on access to healthcare in prisons. I have had several dealings with Her Majesty's Prison Edinburgh; constituents of mine are in there, and I have heard from them quite shocking examples of breakdown in access to appropriate primary healthcare. One inmate, who had chronic liver failure, received medical attention only two hours before he died, even though he had been complaining of being in abject pain for some time prior to that. I realise that that is an isolated case, but I wonder whether the panel can reflect on how that sort of thing can be allowed to happen and the provision that exists in Scottish prisons for prisoners who start to feel unwell.

The Convener: Who would like to start? Come on, panel. Theresa—you are not usually shy.

Theresa Fyffe: When we put our report together, we found variation across prisons. There are many examples of very good practice and of people trying to address issues, but, as I have said, there is also variation in that respect, and prisoners' experience will vary according to where they are.

One issue with access to healthcare in prisons is that, when responsibility was transferred from the Scottish Prison Service to the national health service, the decision was based on a review of the service as it was, and no health intelligence work was carried out on what demand might be. The service went in as it was, without issues that were subsequently highlighted in our report—for example, mental health and addictions—being assessed for demand. Demand existed but could not be met because of where the service was at the time. It does not surprise me that issues arose, because it was thought that there would be a more continuous service.

Another issue is access to different disciplines in the team. Our report shows that nearer the out-of-hours period, it becomes difficult to access a general practitioner or other team members, simply because of the nature of the service. At such times, some prisoners will experience a gap or a very slow process.

Finally, though, we need to talk about not only health provision but the custodial element. If prison officers do not have enough time to support

prisoners to go where they need to go or to access the treatment that is available, that acts as a barrier. In short, there are two issues: first, health provision being less available and secondly, ensuring that prisoners can access therapeutic interventions or attend appointments in the face of dilemmas. Both are working against the system for prisoners at the moment.

Professor Holloway: I concur with Theresa Fyffe. In our submission, we highlight our work with NHS Lothian on a nurse-led model of healthcare delivery. When, as part of that work, we started to identify how to respond to need, we became aware that we did not know what the need was. There is therefore an issue about knowing what the health needs of the prison population are. We do not really have the full data available, and it is very difficult for us to access it. That is one of the fundamental and key issues.

Sandra Campbell: I find it very sad that someone was denied healthcare at the end of their life. In the past few years, a lot of work has been done on collaborative working between the Scottish Prison Service and the NHS to identify patients who might represent prisons' changing population. There is an increasing need to understand and recognise when end-of-life care might be required or when there might be a change or deterioration in a person's condition.

Macmillan Cancer Support, the Scottish Prison Service and NHS boards have done a lot of work on that, and it has led to the appointment just this year of a Macmillan-funded nurse, who is being hosted in NHS Forth Valley because of the work that has been carried out at Glenochil prison. We found in Forth Valley that there was sometimes a lack of understanding of the workings of and the culture in each organisation, so in 2012 we held a very simple stakeholder event, as a result of which we developed pathways of care around cancer—to allow prisoners to access investigations quickly—and around end-of-life care, not just for cancer but for non-malignant diseases.

As I have said, a lot of work has been going on. We are replicating the work on anticipatory care planning and the identification of needs that is going on the community, all of which fits with the strategic framework. The person in that new nurse post will compile a scoping exercise across Scotland and work with the prisons, prison staff, organisations involved in health and social care, local hospices and so on to find out how we can work together to ensure that prisoners who will end their lives in custody have the correct support on their journey and access to services when they need them.

That is just a very brief summary of where we are. A lot of work still has to be done to improve end-of-life care.

Alex Cole-Hamilton: I want to expand the discussion to mental health. Further research and also discussions with prisoners in HMP Edinburgh suggest that there is sometimes a gap in our knowledge of mental ill health in the general population, outside secure units and the state hospital. We do not necessarily know how deep those problems run in prisons generally.

In some cases, which may be localised, there seems to be under-reporting of suicide, with some deaths being recorded as death by misadventure rather than suicide, so that we are not entirely sure of the correlation with mental health.

What psychiatric support is provided and what access do prisoners have to it, both within the general prison population—given that being incarcerated will have an impact on anybody's mental health—and in particular for prisoners with underlying clinical mental health needs? Could the panel offer their views?

The Convener: We met ex-prisoners this morning. One said that he was first put in prison in 1984 and that the difference between then and now was stark in terms of mental health issues among prisoners.

Paul Noyes: That question probably comes to me, for the Mental Welfare Commission.

We have been visiting prisoners for the past 10 years, primarily because a higher proportion of people in prison have mental health issues than is the case in the general population. That is borne out by virtually any study.

One of the difficulties in talking about mental ill health is what we mean. Is it severe and enduring mental health problems, of which there are higher rates in prison—for example 5 to 8 per cent of people in prison have schizophrenia or psychosis—or does it also cover individuals with impaired mental wellbeing?

The issues that nurses are dealing with in prison include anxiety, depression, issues about sleep and sleep deprivation, and the reality of being in custody, which is not a therapeutic environment, but a difficult one in which people need to survive in their own way.

We visit mental health services in all prisons across Scotland every two to three years—I can only speak about those services. We visit more often if there are particular issues. We talk with the mental health nurses who are providing the services, the psychiatrists, and as many prisoners who are using the mental health services as possible.

A lot of prisoners whom we speak to are very pleased and happy with the support that they receive, though many wish that they could get more. One issue that comes up is how quickly

people get support. There can be a wait, and how quickly and how often people are seen varies a lot across prisons.

Prison is not a hospital. It is largely a primary care service. We hope that people who are acutely unwell would be transferred and get the appropriate medical care that they need. In most situations, that does happen.

The original question was about the level of need and numbers. Need is high and demands on services are high, and a lot of that falls to mental health nurses, who deal with a lot of general issues, family difficulties and things that cause anxiety. Most prisoners are very appreciative of the service.

To get a figure is very difficult, as it is for the general population. Incidence of impaired mental wellbeing is very high among male prisoners and probably even higher among female prisoners—the Angiolini report, "Commission on Women Offenders: Final Report 2012" said that about 80 per cent of female prisoners were affected. The big question is what can be done. Nurses are able to talk with prisoners and there is often a lot of self-help and general observation and support. The big gaps are in low-intensity psychological therapies, which people might get in primary care services, and inputs to psychology.

10:30

David Liddell: There is a huge overlap between people with mental health problems and those with drug and alcohol problems. That constellation of problems needs to be considered for the most vulnerable populations.

To go back to the original question about variation, we see considerable variation across the prison estate in treatment for drug problems. It would be fair to say that, in many cases, the treatment that is on offer would be considered poor practice in the community. I am thinking in particular of opioid replacement therapy, which links to underlying issues of mental health. If people are not appropriately treated, issues such as underlying childhood trauma, for instance, come to the fore. We have seen that in the women's prison in particular, where there is self-harm and so on among women who have been on opioid replacement therapy in the community that has not been continued in prison. That is one of the key areas that we would consider.

I highlight the "Drugs, Alcohol and Tobacco Health Services in Scottish Prisons: Guidance for Quality Service Delivery" report from the national prisoner healthcare network; we strongly suggest that the recommendations in that report be put in place. Also, the new "Drug Misuse and Dependence: UK Guidelines on Clinical Management" are coming out. Those United Kingdom guidelines for good practice need to be adopted in prisons, so that we do not have issues of suboptimal treatment in that setting.

On general healthcare, we have recently been doing a lot of work with people over 35 with drug problems, considering aspects of their general health. We have found that general health issues are often not picked up or dealt with because the presenting problem is drugs or alcohol. A wide range of issues are not being effectively dealt with in the community, and prison is potentially a useful point for picking up underlying health issues that are not being dealt with. Regarding hepatitis C, for example, much more could be done to deliver dried blood spot testing at the point of admission to hospital. A whole range of things could be improved.

We now have quite good data on the wider healthcare needs of that population, many of whom end up, at points, within the prison system.

Alison Johnstone: I was quite surprised that the British Psychological Society noted that the Government's 18-week referral-to-treatment time for accessing psychological therapies does not apply to prisoners. Do you have a comment on that, Mr Noyes? I was quite shocked to realise that that was the case.

Paul Noyes: I cannot make any major comment on that, apart from saying that we are very much aware that there is a huge need to increase access to psychological therapies and care for prisoners. People are probably struggling with that target in the community in many ways. I am not sure quite how other targets for physical healthcare apply within prisons. That is not something that I can comment on particularly.

Alison Johnstone: It seems to be a question of equity. That seems to be discriminatory, in my view.

Paul Noyes: Yes.

The Convener: Is that a legislative exemption?

Alison Johnstone: I do not know. The British Psychological Society just noted in its submission that the Government's 18-week referral-to-treatment time for accessing psychological therapies does not apply to prisoners.

The Convener: We will check that out.

Alison Johnstone: Thank you.

I wish to ask Mr Liddell a question. Neil Findlay and I were speaking to the same gentleman, who said that, when he was in prison before, in 1984 or 1985, it was full of criminals, as he referred to them—he gave us a list of the crimes that they had committed. He feels that the prison population has changed markedly and that there are now far

more people in them with poor mental health and drug-related conditions. He said that he was one of eight prisoners who tried to get off their drug habit. He said that, out of the eight, he was the only one who managed, and he was clean in prison for eight months. When he came out, however, he had a needle in his arm within 72 hours. Lack of support at the transition time was a huge issue.

He spoke about people who left prison on a Friday evening with nowhere to go and little money, and who were quickly sucked back into something that many of the prisoners had clearly been trying to tackle in prison. They wanted access to services, which were sometimes difficult to come by. That was somebody who had made huge efforts while in prison and who was thwarted when he got out. There was also a case of someone who was let out just before Christmas, an even worse time, without any support. Why are we still getting that wrong?

David Liddell: One element of that is to keep larger numbers of people out of the prison system altogether. Drug treatment and testing orders have played a useful role, but we could do far more by way of alternatives to custody. As the person you spoke to suggested, there is a large vulnerable population in prison who would be better off not being in that environment at all.

It is very hard to become drug free in prison and there are substantial risks on liberation. That goes back to a point that the Royal College of Nursing made about the wider aspects of the matter, such as people's benefits and their housing. People who are in prison for a lengthy period often lose their accommodation. All those issues mean that people are generally worse off at the point of liberation, rather than in a better position. That is hugely challenging.

A new voluntary throughcare system is available through the Scottish Prison Service, but we have questions about the extent to which it actually delivers to the needs of the most vulnerable populations, who experience particular challenges at the point of release. That sometimes applies to individuals who have had a drug problem for 20 years or so. We have to be realistic about the ability of people to remain drug free at the point of release. That is where the opioid replacement therapy would come in for most individuals—but not for all. It is about people's choice to become drug free in that environment. The evidence suggests that it is extremely hard for people to maintain that in the community.

I take your point about effective support, which is another challenge. It should not be left to Scottish Prison Service throughcare staff to deliver community services. There need to be better links, both going into prison and on release from prison. It is about continuity of care for vulnerable people.

Alison Johnstone: On the issue of opioid replacement, some prisoners suggested that they had never been on opioids in the first place, but that they found themselves on methadone. There was a feeling that it perhaps made it easier to look after prisoners. People who had never really had a drug habit found themselves coming out of prison with one.

David Liddell: But they had been using previously. It is unlikely that someone who had not been using drugs would be put on methadone. I find that slightly hard to believe.

Alison Johnstone: I was given the—

David Liddell: I guess it is more about ensuring that that provision is appropriate. I think that the figures indicated 1,000 or so people on methadone, and probably a few hundred on buprenorphine, which is another substitute drug. Our sense is that that provision is less than it should be.

However, I take your point that treatment must be delivered in a person-centred way. That is another big challenge in prison: how to deliver person-centred care to large numbers of people when services are stretched.

Alison Johnstone: It was discussed that someone had co-codamol in their bloodstream and, as an alternative, found themselves on a methadone programme. The description that I was given of that scenario was that it was like "Meerkat Manor", in that prisoners are aware that prescriptions are being given out, everyone is watching everyone else to see what they come back to their cells with and sometimes vulnerable prisoners are preyed upon for what they might have, which is traded or just confiscated by stronger characters. Is there anything that can be done about how prisoners receive drugs that they need?

David Liddell: Those issues are hugely problematic in the prison environment. One of the things that we saw with buprenorphine was that people took it in their mouth and were able to take it away and sell it to other prisoners. In one prison that was dealt with by crushing the tablets before they were given to prisoners.

All those issues are very difficult to manage. If you focus heavily on issues around potential leakage you can damage the person-centred nature of the service. Those issues have always been there and they are more severe now because there are large numbers of people with drug problems. In many respects those individuals are much more easily managed in the community

and potentially should not be in prison in the first place.

There will always be difficult management issues in the custodial environment.

Paul Noyes: One of the big issues that prisoners speak to us about is whether they are getting the right medication. We have come across a lot of issues with people coming into prison not continuing on the medication that they have successfully been managed on in the community. Prisoners often say to us, "They think we're at it, they think we're trying to get drugs". Getting that balance right is hugely difficult. The amount of time allowed for being given medication is also a huge issue that is very difficult to deal with. That is the reality of the situation.

Alison Douglas: One of the key issues is the identification of prisoners with alcohol problems. From one study we know that the prevalence of dependence in the prison population is up to 36 per cent, in comparison with the prevalence in the general population, which is 1 per cent. There is a real concentration of alcohol issues in the prison population and there is still no consistent identification of prisoners with alcohol issues when they enter prison. It still tends to be a yes-no question that is put on entry, rather than there being a systematic screening tool. The consequences of that means that unless prisoners subsequently self-identify, they are unlikely to get access to the treatment that they need.

Alcohol may be seen as less of an immediate priority in the prison setting because only 4 per cent of prisoners say that they have access to alcohol so clearly drugs are more prevalent. However, when prisoners are released and walk out of the prison they might be what they call "gate happy" and having a drink or drinking to excess will potentially be one of the first things that they think about doing.

The perception of prisoners is that access to treatment has reduced over the last few years. The number of prisoners who say that they have received treatment has dropped from 23 per cent in 2011 to 14 per cent in 2015. That is a cause for concern, because prison provides an opportunity to deal with alcohol behaviours that have a significant impact on the individual, their relationships and offending behaviour. A high proportion of prisoners—41 per cent—link their offending to their alcohol use and say that they were drunk at the time of their offence. That percentage rises for young offenders.

In prison there is a real opportunity to identify and start treating people who have profound alcohol problems. As was mentioned earlier, there is then an issue about the continuity of such care on release, because the opportunities are much more significant outside prison than in the prison setting.

The Convener: Having attended the informal evidence sessions last week and this morning, my understanding is that the dominant issue is throughcare and that that is where the major failure is. We heard from Sacro and from ex-servicemen who have gone through the system with assistance from Sacro. They said that before Sacro intervened they were released from prison with a poly bag containing their clothes and a 70 quid grant—they walked out of the door to nothing. With Sacro's support, those men had someone assisting them to get a roof over their head, to claim benefits, to register with a doctor and all of that. The young people on the new routes scheme, which is open to up to 25-year-olds, were also getting that assistance.

10:45

Those services do not exist for everyone else and those people were talking about registering for benefits, which take a while to come, so they have no money in the meantime. They also talked about how you cannot register for a doctor if you do not have an address and how it is no surprise that in that cycle people resort to crime to try to feed themselves and get a roof over their heads until everything settles.

Is the major breakdown in the system the lack of throughcare to prevent people from coming back in? If so, why are all prisoners not offered the support that is given by Sacro or new routes? If someone is over 25 and not an ex-serviceman, it appears that they are on their own.

Professor Holloway: There are so many things coming up in the discussion it is hard to decide which to address. There have to be some distinctions. We are talking about a prison population as a generic group of people, but it is not. The biggest distinction is between the needs of male and female prisoners, but there is also a big distinction between remand and non-remand prisoners.

The work that we have been doing and current evidence show that remand prisoners are a very high-risk group among whom the things that we are discussing today occur more frequently because of the nature of their offences and the amount of time that they spend in prison. For example, when remand prisoners go to court, they are released straight away—they do not go back to the prison and do not pick up their mobile phone and belongings. We then have difficulty in engaging with them in the community, even when there are services available for them.

We need to be aware that we are not talking about a group of people with the same needs. I

strongly recommend that the committee takes into account that awareness about remand prisoners. That picks up on your point about throughcare, convener. If someone is sentenced, they know when they will be liberated and we are more able put in place structures to help. That is very difficult for remand prisoners, so it does not happen. Likewise, when remand prisoners are inducted into prison, they are not made aware of the services and support that are available to them.

Theresa Fyffe: I agree entirely with what Aisha Holloway has just said—that is what her report showed.

There is also a gender issue. The committee may recall the nursing at the edge work that we did, where we demonstrated the one-stop women's learning service—OWLS—that was offered in another part of Scotland. That service supports women coming out of prison or those who are not going into prison but doing what is required for their crime in another way. That enabled women to be more supported, rather than finding themselves far from their families and children.

I want to go back to the point about continuity. As members will have read in our evidence, the nurses who are working in the Prison Service—mental health nurses in particular—feel quite deskilled because medication has become the issue. They go in thinking that they are a mental health nurse with a range of cognitive behavioural skills that they want to bring to the fore, but medication has become the prime issue. I visited a prison a while ago where the psychologist was in the prison waiting to do some group work but there was not enough custodial support to bring the prisoners to the group.

Mental health nurses have become deskilled and that means that there will be a recruitment issue because the medications model is way back in the past and that is not what mental health nurses today would want to be doing. You will find that mental health nurses will not be attracted to working in the Prison Service. There are now a lot of agency workers working in the prisons and they are just going around giving out medicines. That is not a good way to go forward.

We have also done some work in forensic services on the route that people take, which relates to the point that Aisha Holloway made about remand. Assessing people appropriately before they are put into prison is going really well in areas that have clinics. The clinics can very quickly assess whether somebody is there not because of what they have done, but because of their mental health condition. Sadly, people who have a learning disability and/or a vulnerability can be in the wrong place. They end up going into the system, whereas at that point, if the support is there, they can be looked after more appropriately.

A nurse in one of those services said to me recently that they have now been working there long enough to see the turnaround. They recognise clients whom they have seen before, who have been through the system and been released, and who have come back in a very short period of time. That fits with what my colleagues have said about people being unable to get their feet on the ground. Their return is shockingly quick and the nurses are seeing that day-to-day evidence. That impacts on the morale of the healthcare workforce and the service that people think that they can provide, which will affect continuity. No service is then provided on the cognitive behavioural model that I spoke of—the really close interventions that mental health nurses can make that bring about the difference.

Donald Cameron: To corroborate what Theresa Fyffe said, from the conversations that I had this week and last, there is clearly a gap in mental health provision in prisons.

I want to ask a specific question that goes back to what David Liddell said about the interplay between addictions and mental health. There is often an overlap. One of the former prisoners that I spoke to, who did not have any addiction issues but did have mental health issues that he spoke about, said that he felt that addiction was prioritised as a health problem at the expense of purely mental health problems. He felt at the back of the queue, in effect.

Does anyone have any observations on that?

David Liddell: It should not be that way. We did a recent study looking at the life histories of 56 problem drug users. In half of the group, childhood trauma came out very strongly. For many of those individuals, the drug problem is the presenting problem, not the key problem.

We need to get the mental health provision right, then some of the addiction issues will be resolved. That is a common refrain from people. They go to services but the services do not have the time to find out how the people got into the state that they are in. The services deal with the presenting issue, which is the addiction, rather than with the underlying causes.

I do not know whether that answers your question, but it is not straightforward. The numbers going into prison with addiction problems will in some respects overwhelm the service. That goes back to some of the issues around the dispensing of medication. We need to look at the whole prison system to see whether there are better ways to deliver the service, so that the workers do not spend all their time dispensing but have more time to build therapeutic relationships,

which is the element that will deliver the results that we are looking for.

Alison Douglas: I wonder whether one of the things that the former prisoner was identifying was the provision of detox services or treatment for physiological addiction, as opposed to the recovery-oriented care of psychological therapies. I suspect that there is a deficit of psychological therapies in general for mental health or mental health and addiction issues, as opposed to what prisoners may see as detox or medical prescribing.

Clare Haughey: I will pick up on something that the convener said about throughput support. I have heard good examples this week—as I did last week—of the Prison Service's throughput support and how that has transformed lives. There is a wide range of throughcare services that we need to acknowledge.

Before I go on to my main question, I have something to ask Paul Noyes from the Mental Welfare Commission. You said that the commission has been looking at prison mental health care for the past 10 years. Who oversaw mental health care provision in prisons before that?

Paul Noyes: I am not sure that I can answer that. We tend to visit mainly hospitals, as well as community facilities. The commission met representatives of the SPS about 10 years ago, before I started to work at the commission—I could get the details—and we achieved an agreement that we would visit prisons, given the level of identified needs and issues coming out of them.

We have debated our role in prisons for a while. We are not an inspection agency. We tend to ask prisoners about the care that they receive, and we can react, follow through and make recommendations. We were visiting prisons prior to the transfer from the SPS to local health boards.

We did a report on the mental health of prisoners nearly six years ago—in 2011—that considered the issues at that time. We pass on to health boards our reports, which raise issues that we pick up, but we also share information with HM inspectorate of prisons for Scotland and Healthcare Improvement Scotland. When prisons are inspected, those bodies primarily consider standards for healthcare and mental health care. We liaise quite closely, and we can pick up on issues from our visits and those organisations' visits. That is effective in highlighting issues that we pick up. We do make recommendations.

We find that the situation is quite variable—there are good points and less good points, often in the same prison. The picture varies, and we pick up on that and make recommendations—for instance, on inadequate healthcare and health centre facilities and on time being wasted when psychiatrists cannot get a room because they have to wait behind the general practitioner.

As has been mentioned, a good relationship is needed between health staff and prison officers. There is no point in having a psychologist visiting if nobody brings the prisoner across. There is a whole dynamic whereby people need to work together.

We have been going into prisons for a while, and we have seen the situation with the SPS and then the health boards providing a service. We have not seen huge changes. There has been a chipping away, and nurses who work in the healthcare teams in prisons now have the opportunity to be much more connected with health boards and with training. We would like much more transferring back and forth between nurses who work in the community and those who work in prisons, so that we can build bridges and find out what is happening in the community and in prisons. That does not happen a lot, although it is beginning to happen more.

One big thing about the change from the SPS to the NHS is maintaining the links and relationships. Our experience is that staff turnover has not been massive, and healthcare staff who work in prisons have often been there for a while. They have good relationships with the prison officers, and much is built on trust and on who they know. Maintaining the dynamic is important.

With the service having moved to the NHS, the danger is that there could be more of a gap between the two services. Both services need each other to do their jobs properly, and we want to ensure that that continues to happen.

I am sorry—I have probably gone away from the question.

Clare Haughey: Absolutely—I am still no clearer. Who inspected prison mental health services? There were previously such services in prisons. If you do not know the answer, you do not know the answer.

Paul Noyes: We do not inspect the services; we visit them. The answer is probably HM inspectorate of prisons for Scotland.

Clare Haughey: To follow on from what Mr Noyes said, I will ask the panel an open question. We heard last week when we were talking to healthcare professionals who work in prison services, and we have heard today from prisoners who were in several prisons during their time in custody, about inconsistencies across the prison estate and varying levels of care, treatment and access to treatment. Will the panel give us insight

into how we can ensure consistency of services and access to services across the prison estate?

11:00

The Convener: I have a point that I was going to raise at the end, but it could perhaps be discussed now. Someone mentioned the role of the governor in setting the atmosphere and the culture. Perhaps the witnesses could also refer to that.

Theresa Fyffe: Exactly—I was going to come to that.

There is no doubt that there are examples of very good practice. In fact, one of the prisons to which my colleague Sandra Campbell referred recently won an award for some of its work. I know that she has done work as a palliative care consultant that has transformed end-of-life care in a way that has been opened to the culture of the prison.

I have visited many prisons over the years; I always go in to meet our members who work in them. I have learned, so when I go in, I can tell what the atmosphere is like, which I would not have known or understood in the past. I would go in and understand that there was joined-up working. Just like Clare Haughey, I was shocked when I went in and discovered that there were not rooms, which I asked about. One place had an amazing, state-of-the-art room for the dentist, who had a dental chair and all the equipment that they required; it also had a room for the GP and a therapeutic room. However, I went to another place that had nothing like that at all. The infrastructure that is provided for access to prisoner healthcare differs.

The issue is without doubt about the relationship. As a college, we were absolutely for the transfer. We worked alongside it and thought that it was the right direction to go in. We still believe that, despite the questions that we have come out with. The worry was that there would be a break in the relationship between the Scottish Prison Service and the health elements. I have not seen that everywhere, so such an approach can be taken, but I have seen it in places where not such a good relationship has been fostered between the healthcare staff and the Prison Service. That worries me.

I was in a prison where I saw a group set up, so I asked questions such as, "What is that man sitting over there waiting to do? What is happening?" Suddenly, right in front of me, I saw that the staff were unable to escort prisoners to the sessions. The healthcare professionals who had come in were distressed that they could not do their job.

Culture has a lot to do with this, as does leadership, without question. It is about a transformation of thinking. If the capacity of the healthcare workforce is not right, that will not work, either. If there are not the right mental health nurses and other nurses dealing with health needs, the service will be rationed, because those nurses will simply end up doing what they can do.

What comes across is that the staff work extremely hard. They do the best job that they can but, if there are not enough of them to do what they are required to do, they will feel disillusioned and the relationship will not be the same.

Sandra Campbell: I will share some really good practice that shows what can be achieved with collaborative working. Education for prison staff was mentioned. As part of work under the national end-of-life care project, which is working in partnership with Macmillan, the Scottish Prison Service and the NHS, we worked with NHS Forth Valley to make Glenochil the pilot site for a post more than a year ago. We have been providing the prison staff with end-of-life care education, so that they have access to the same education as we offer the staff of NHS Forth Valley. We go into the prison, work with the team and provide education, as does the local hospice.

There was a suggestion at the national group about teaching a SAGE and THYME workshop, which is a communication skills session to elicit and manage emotional distress for all. Glenochil has a buddy system, whereby prisoners who might be less able to self-manage are supported by their prisoner peers.

We taught some buddies the communication skills model, which includes assessing for suicide risk, and that worked well. Alongside the prisoners, we taught prison officers, other staff and carers. Where there are good working relationships between two organisations, that benefits the prisoner population.

David Liddell: I go back to the point about how things have changed. The report from this time last year—"Drugs, Alcohol and Tobacco Health Services in Scottish Prisons: Guidance for Quality Service Delivery"—had a list of recommendations on leadership and governance. The problem is that that is guidance. The frustration is about how we move from understanding what the problems are to changing the situation. That relates particularly to differences in practice.

I will not mention particular prisons or health board areas, but we have seen some very poor practice. When that is challenged, the point is often made that for things to happen, individuals—rather than organisations such as ours—have to make complaints. Getting to grips with prisoners' experience and understanding of what the

problems are is a big issue, so that we can move beyond knowing what the problems are and start to address them over the long term.

The Convener: David Liddell referred to recommendations, and Paul Noyes referred to a report that his guys did in 2011. Were the recommendations from that implemented?

Paul Noyes: The recommendations have been looked at by the co-ordinating group for prison mental health with a recommendation that they should be followed, but progress is slow.

The Convener: The recommendations have been looked at but not implemented.

Paul Noyes: They have not been fully implemented.

Alex Cole-Hamilton: A group in the prisoner population that politicians often forget about—because they are very small in numbers and stature—is babies. I refer members to my entry in the register of members' interests, as I worked for an organisation that provided a service for the mother and baby unit at HMP Cornton Vale.

I ask the panel members with an interest in the field about the impact of being in prison on the development and early health needs of babies. Is the balance now right? Will the child and family impact assessments brought in by Mary Fee in the previous parliamentary session change things for the better? Will we find a different way of dealing with offenders who are new mothers?

The Convener: We are talking about health; I know that the issue is health related.

Alex Cole-Hamilton: Absolutely—it is about a health need.

Theresa Fyffe: I will keep the answer short. I am not an expert on the issue, but our work on nursing at the edge was about other ways to support women with babies outside the main prison. Lots of excellent voluntary sector work is enabling that. It shocked me to discover that women—particularly if they have children—lose more support from outside than men do. The rate of visiting of men by women or the family is higher than the visiting rate for women. Women are isolated from their family then try to go back out.

Services such as OWLS in Perthshire, which I mentioned earlier, have been fantastic at transforming the position of women and children. That is a better approach than thinking about a custodial service that has ways of offering support. Often, it is what was happening to women that led them to commit crime, so the situation could be handled differently. We did that work to promote a different way to look at women, especially when children are involved.

Alex Cole-Hamilton: Regardless of whether a baby is with the mother in Cornton Vale, what support is there for perinatal mental health needs? We know that such support is a problem in wider society. Will you explain what provision there is in prisons?

Theresa Fyffe: I am sorry—I cannot comment on that.

Maree Todd: I have been struck that almost all the people I have spoken to over the past few weeks—I visited Inverness prison and I met the people who came to the Parliament—have mentioned that the point of liberation is a risk. There seems to be a lot of homelessness at that point, which makes it difficult to have continuity of care or to engage with healthcare.

The more severe the crime, the better the planning seems to be. If a person is on a long sentence, the planning is very good. If they are on a shorter sentence, there will be some planning but, if they are on remand, they will almost be tipped out into chaos.

Homelessness is maybe not a health issue, but shelter is a basic need in the holistic picture. This morning, I spoke to a man who is 27 who said that he had been in and out of prison since he was 19 and that he has never had his own accommodation in that time. It seems that we could do better for such people.

Professor Holloway: I agree. We recently surveyed almost 200 remand prisoners in a Scottish prison and then interviewed them in depth. We looked at alcohol interventions across the spectrum and not just at alcohol dependence but at harmful and hazardous consumption that puts people or their health at risk. The key thing that the majority of those prisoners said was that, when they got out of prison, they would need help to deal with not just alcohol but employment, housing and benefits.

A challenge that we face is that, although we have evidence of the effectiveness of alcohol interventions in other settings, the dynamics and nature of the prison setting, with power balances and the high anxiety in it, mean that we are less sure of what is most effective there. That is one of the things that we are trying to deal with, and such interventions are one of a number of things that have to be put in place. If we have a conversation with someone about their alcohol consumption, we cannot expect them to change their behaviour without providing support on all the other things that impact on health, offending and reoffending. The current model is not cost effective for us in the long term if we want to support those people.

Maree Todd: I have a background of working in psychiatry—I was a pharmacist who worked in mental health for 20 years. I was struck that the

model of recovery-oriented systems of care that we use outside prisons, which builds on people's strength and resilience, is difficult to use in prisons, because responsibility is removed from the prisoner.

Professor Holloway: Prisoners are disempowered.

Maree Todd: Yes—they are disempowered and institutionalised. That basic tension is striking. How do we get round that? I wonder about not just healthcare professionals but voluntary services being able to go into and out of prisons. Organisations such as Alcoholics Anonymous and Narcotics Anonymous are helpful in the treatment of addiction on the outside. What are the barriers to them getting involved in the prison system? How easy is that? How easy is it for people who have had addiction problems and have turned their lives around to get into and out of the prison system? This morning, I heard from a chap that a person can volunteer as a sponsor in the prison system. However, once a person has been released from prison, they cannot volunteer to work for the Samaritans for two years.

Does anybody want to have a go at answering that?

Theresa Fyffe: You have described exactly what the issue is. If we have to change the model—I believe that we have to do that—we have to look at how we will open it up to the breadth of services. We want to have the right number of mental health nurses, but there should not be just mental health nurses; there should be a multidisciplinary and multi-agency approach. There can be ways of doing things.

The issue goes back to the culture of the prison and thinking about how a prison can change that and enable that change. That is the challenge. If that is not done, we will not have the most cost-effective model and we will be watching people go out of and back into prison again.

Maree Todd: That seems to be an expensive way to make the problem worse.

Theresa Fyffe: It is. That is what the staff in custody suites say to me. They almost recognise somebody who will go out and come back in again, and that applies especially if the prisoner has been a remand or short-term prisoner.

I refer to a point that the convener made. There are definite models, but an enormous number of people fall through the gaps.

David Liddell: I have made the point that large numbers of prisoners are vulnerable. The key issue for them is preventing them from going to prison in the first place. The study that we have just done of individuals over 35 with a drug problem showed the number of times that those individuals had gone into and out of treatment and into and out of custody. I think that AFS talked about the revolving door, which is a huge issue.

11:15

An element of the narrative of many of those whom we are talking about is that no one has stood by them over a long period. We have talked about some of the services that can do that. The challenge is to get services to stick with people, rather than to be relieved—as a result of the pressures on the service that mean that it cannot follow those people up—when people drop out of the service.

Alison Douglas: I will build on the point that Dave Liddell made. Scottish Government direct funding for alcohol and drug services has been reduced by 22 per cent in the current financial year. For the future, alcohol and drug provision is being folded into the general provision for health boards.

We know that the things that are likely to drop off are recovery-oriented systems of care, because they require longer-term and more in-depth engagement with individuals. That is deeply concerning. If we recognise that we are not getting the provision right, if continuity of care is a major concern and if we are not managing to implement the quality service standards, I am a bit nervous about the future, given the financial context.

Maree Todd: I want to ask David Liddell some specific questions about drug treatments. You said that the orange guidelines are not being adhered to in prison. Is that correct?

David Liddell: There are draft orange guidelines, and new ones will be published shortly. Our recommendation is that they should be adhered to. A lot of drug treatment practice in prison is sub-optimal and not of the standard expected in the community. That needs to be addressed. One way is to adhere to the UK clinical guidelines.

Maree Todd: Would an audit or Scottish patient safety programme methodology tackle that on the ground? You have said already that there have been guidelines but that the gap between practice and guidance has not closed.

David Liddell: Yes. One way of looking at it would be through Healthcare Improvement Scotland as part of the current prison inspection regime. We have been involved in a few of those inspections. It is important that the inspections include expertise on mental health and addictions, given that those affect such a large proportion of the prison population.

Maree Todd: The other specific question was about naloxone provision. There is a serious risk

of overdose at the point of liberation. What do you think about the naloxone strategy?

David Liddell: We have been working hard on it, and during the past few months, our staff have been in prisons training night staff in naloxone. One of the issues is that, if someone overdoses during the night, there is no medical cover and therefore no one to administer naloxone. That is an internal issue that we hope is being resolved.

One of the other issues that we have been working with SPS and others on is ensuring that every prisoner who is at risk of an opioid overdose or has peers who are at risk should be given naloxone. We could work a lot harder at making that an opt-out rather than an opt-in provision. There are ways to do that, and we are working closely with the SPS to increase the numbers who have it. It is an important area. As we have seen, and as you said, the point of liberation is a high-risk moment for people, as are transitions from hospital or a residential facility.

Maree Todd: This morning, I spoke to a number of people about the potential for peer support, using volunteers and sharing lived experience in prison. The final issue that we considered was how the prison population could be trained to deliver social care, which would give them an opportunity to work in the prison and some skills to take with them when they left prison. Will Sandra Campbell say something about that? I think that you mentioned projects that do something like that.

Sandra Campbell: I can talk only from the end-of-life care perspective—please bear with me. We have learned from models in England. When a prisoner's condition deteriorates, they might have an increasing need for assistance with washing and other activities of daily living. For some prisoners who have been in prison for a number of years, the closest people to them might be other prisoners; in essence, they are their family. There are buddy systems, whereby the buddy prisoner—as it were—supports the individual to live as long and as well as possible.

In Glenochil prison, the staff have adopted that model, to a degree. There are also social carers in the prison. One of the nurses who has been appointed focuses on rehabilitation and supporting people who have multiple co-morbidities. The prison staff are supported to understand such individuals' changing needs and to consider anticipatory care planning for them. Alongside that, some prisoners help with the care of those prisoners.

It is a good model. Of course, it has to be well supervised and supported, and it has to be safe. It is a person-centred approach, because prisoners are other prisoners' family. The approach gives people skills that they can use when they leave prison.

The Convener: There are going to be more older prisoners and many such people, if they were not in prison, would be in a care home, sheltered housing or something similar. Should we create a new environment, such as a secure care home, for such prisoners? Prisons are the last place where people with mobility problems and particular conditions should be, given prison design—the stairs, halls, beds, eating arrangements and toilets are not conducive to meeting people's social care needs in a dignified way. Should we create a new model?

Sandra Campbell: I cannot comment on that in the wider sense, but I hear what you are saying. Certainly on a smaller scale, in Glenochil—again, following a model in English prisons—groups of prisoners who have particular needs are managed together in the same wing, where social care staff can support them. However, the prison environment is difficult. Things like the width of cells and beds and access for wheelchairs are not conducive to good care.

Colin Smyth: We have talked about continuity of care a number of times. In its submission, the British Medical Association said that workforce issues are a barrier to continuity of care, and the RCN said, in its submission:

> "Staffing is ... a very real pressure in delivering adequate healthcare in Scotland's prisons."

Are there specific workforce issues for prison healthcare? If so, what does it mean for prisoners' access to healthcare? Is there a recognised workforce model for healthcare in prisons?

Theresa Fyffe: There is not a recognised workforce model. As I said, when the review happened, healthcare transferred over as it was. There is work to be done on the nature of the team that works in prison healthcare. That takes us back to Maree Todd's point; it is very much about a multi-agency approach and a different way of working. That is what I would go for.

There is a shortage of registered nurses in Scotland anyway, so if there is a recruitment and retention issue in some areas, prisons will suffer from that. It takes a particular type of person to wants to work in the Prison Service. When you meet people who love it and who see it as their job to do it, it is amazing to see, but as I mentioned, morale is such that if people cannot do the job that they came into the health service to do, we end up not being able to recruit. I am referring in particular to mental health nurses and the equivalent of community nurses because, as has been said, we are talking about the provision of community care—in other words, more general care. There is an issue with recruitment and retention, and there

is an overdependence on agency staff within nursing.

In addition, as I mentioned, our report found that we do not have enough GP cover. Out-of-hours provision is very slow and people have to wait a long time for a call-out. That is a big gap, which means that the night staff are under a lot of pressure when something happens, because they have to wait for someone to turn up and do what is required.

There are new protocols—my colleague mentioned drug provision. I worked with the Prison Service prior to the transfer and found that we could not change the models. I was in favour of the transfer, because I believed that it would lead to a change in the models of care. Five years on, I am not seeing that across the board, so I think that the shift has to be different. It must reflect the way in which we care for people within the community in the context of the Prison Service. We need to rethink the model and we now have an opportunity to do that. I would prefer to look at the kind of model that we should have rather than just talking about the number of nurses.

David Liddell: At the point at which the transfer occurred, every prison had a social care service through Phoenix Futures. Initially, that was also a throughcare service. At the point of transfer, without fail, every health board took that service in-house; the voluntary sector social care model was not retained. We should be looking at such flexible models as well. It is not just a medical issue; it is a medical and social care issue, as has been emphasised.

Colin Smyth: I want to follow up on that. What work is being done to develop models across the service? Obviously, different prisons will have different needs. Is there a gap?

Theresa Fyffe: It depends on the board. Provision was made at national level, but it was not clear where responsibility for that was to sit within Healthcare Improvement Scotland. It is time to look at where the national leadership sits. Within boards, it depends on who has the lead. In boards in which people have a defined lead role for prison services, more will be happening. In boards in which there is variation, less will be happening.

Responsibility for prison healthcare was handed over to the boards. Some boards have more prisons than others, and for those boards it was a big agenda. They knew that, and some of the people who took on the role were determined to have an impact. However, the integration of health and social care had not happened at that point. We now have a golden opportunity to rethink what is being done and to think differently about how we provide the service. At the time, the NHS operated by taking things back in-house, and I think that that was a mistake. To be fair, it was a big change. I am no expert on this, but I met people who were not skilled in caring for prisoners who had to learn very quickly. It had been a separate area, and it suddenly became part of their service.

The Convener: We have 15 minutes left, and four more members want to ask questions.

Ivan McKee: I thank the witnesses for coming along. I also thank the clerks for organising the session that we had earlier with ex-offenders. We heard some harrowing tales about people who had been let down by the system.

11:30

I want to dig a wee bit deeper into the issue of reoffending. Is there any evidence or data about where the best practice is, whatever we perceive that to be, or where we do things differently on the provision of mental health or addiction services in the prison environment and in throughcare post release? Is there any data on what impact that has on re-offending rates? Are there any international examples that we can draw on?

I understand that Scotland and the UK in general have a significantly higher prison population than many other countries, which are clearly doing something a bit different. There is clearly a wider context to that, but is there anything specific on investment in mental health and addiction services? If that impacts on reoffending rates, it will impact on the overall cost, because prison is a very expensive place to keep people. That would be a virtuous circle from an investment point of view. Does anybody want to pick that up?

Professor Holloway: I will try. From the evidence base, we understand that there is a relationship but we have not really unpicked the cause and effect of that. We see higher rates of offending in people who have bigger alcohol, drug or mental health problems. One of the challenges that researchers face is to standardise the studies that we undertake to understand the impact of the things that we do on health outcomes, but also on non-health outcomes such as employment, housing, homelessness and family relationships—the wider society.

I am involved in international work that is looking at standardising for alcohol a set of outcomes that we would measure for trials across the board. Everyone would use them internationally. We hope that that will help us to start building the evidence, but, unfortunately, it is not explicitly available yet.

Ivan McKee: We are talking about a lot of ideas for improvement but, without an evidence base, it

is hard to know exactly what works and where to go.

Professor Holloway: One of the challenges is that, when we do work of that nature, it is difficult to follow up prisoners six, 12 or 18 months later. Sometimes there is evidence in the initial stages that something is going on, but it is difficult for us to identify what the longer term impact is.

David Liddell: On the other hand, we have plenty of good practice guidance and documents that tell us what good practice should look like. It is not difficult to compare what we have with what should generally be in place. I talked about the clinical guidelines, and I think that there is enough there to be going on with in terms of knowing what services should look like.

Ivan McKee: I understand that, but my question was whether there is data that says "If you do this, you will get these improved reoffending rates and consequent cost savings." I ask that question because, if we get to the cost-saving number, it will make it much easier to justify the up-front investment.

David Liddell: There is data about the number of people who go through drug treatment and testing orders successfully. There is that data on moving people away from going to prison, but in the prison context it is very complicated to put that in place.

Professor Holloway: The evidence that we submitted to the committee referred to the follow-on piece of work that we are developing that will hopefully answer some of the questions. We will look at health outcomes and at offending behaviour with a health economic analysis.

Richard Lyle: I note from the RCN submission that there are concerns about G4S taking individuals to hospital. On one occasion, a patient had their appointment rescheduled four times because of G4S no-shows. What would the panel suggest that we do to improve that service? At the end of the day, that sort of thing puts a strain on the prison, the prisoner and also on the NHS.

Theresa Fyffe: That is what we were talking about earlier when we spoke about collaborative partnership working. There is no doubt about it—we gave that example—and there were many examples of prisoners being unable to access healthcare or keep appointments because they could not be escorted. There are variations on that, from what I understand. Next week, Aisha Holloway will facilitate a meeting that I will have with a group of stakeholders, which will give us more information on prisoners' experience of not being able to get access to their healthcare.

If we look at the custodial service and the escort of prisoners, we should make the same point about linking them to the health interventions. If someone is delivering a health intervention, they need to know that the custodial service can deliver that health intervention. I have mentioned what I saw on the day that I was in a prison. In fairness, that actually happened because the prison was short of custodial officers. It was not that they did not want to do it; they were too short of people to be able to do it safely in that way. We raised that because questions came back to us all the time, particularly about whether the escort service is able to function to meet the needs of prisoners. We do not believe that it is, everywhere; I cannot say that across the board. There seem to be some notable gaps.

Richard Lyle: I have another question. Prior to coming to this place about six years ago, I had the distinction of being an out-of-hours driver for the NHS, as Theresa Fyffe knows. On the point that she and David Liddell made, we had what we called one-hour calls and four-hour calls, and one night, when I was doing an overnight shift, I had to take a doctor to visit a local prison, and it took about three hours out of the whole shift. What should be improved about the out-of-hours service within the prison estate?

Theresa Fyffe: The model that Sir Lewis Ritchie produced on behalf of the Scottish Government was an out-of-hours model for use out in the community, in which there is a range of roles, such as advanced nurse practitioners and pharmacy roles, for people to do what is required. The whole model is in there. I would take that model and apply it to how the service is provided in prison. I first got involved in prison work because, before we had an out-of-hours service, there was only one GP who could be called out and it became impossible. Therefore, I would not rely on that as a model to get access to treatment; the model has to be a multidisciplinary one. That would just mean looking at the work that is already set out very clearly and applying it to the prisoner world.

Tom Arthur: Good morning, panel. My question would probably be best answered by David Liddell. It concerns blood-borne viruses, specifically hepatitis C. We know that, at a UK level, around 90 per cent of HCV infections are found in people who inject drugs. We also know that 60 per cent of people who inject drugs will spend time in prison. The 2012 study suggests that the prevalence of HCV in the Scottish prison population is 19 per cent. The refreshed sexual health and BBV framework from a couple of years ago states that the Scottish Government is to

"work with NHS Boards and the Scottish Prison Service to introduce opt-out BBV testing ... for all new prisoners ... during their induction period".

However, the submission from the SDF, Hepatitis Scotland and HIV Scotland states that

"Blood-borne virus ... testing is inconsistent and poorly managed overall in prisons".

Clearly, if we are going to realise the World Health Organization goal of eradication by 2030, ensuring that testing occurs in prisons is absolutely vital. What distance do you feel we have yet to travel before we realise what is set out in the framework?

David Liddell: As you say, when people go into prison, there is a huge opportunity for us to pick up those who have not been diagnosed so far. There are significant numbers of individuals—both among those who continue to inject and those who possibly stopped injecting many years before. Our argument was around introducing dried blood spot testing of individuals at the point of admission, and routinely—obviously, with individuals' consent. That would be a way of picking up the numbers of people with HCV and treating them appropriately within the prison context.

Tom Arthur: What do you think the specific problem is? Is the dried blood spot testing the primary barrier? Is that the reason for the "inconsistent and poorly managed" overall approach?

David Liddell: It goes back to that wider issue of not looking at underlying health needs, particularly of people with drug problems. Routinely with addiction, the presenting problem is the focus of attention rather than the underlying health issues. The broad issue is the need to improve the overall level of primary care for individuals in terms of both their general and mental health.

Tom Arthur: What about knowledge within the prison population about the treatments that are available? Many people who are HCV positive are put off treatment by the prospect of interferon, but other quick and effective treatments are now available. Is there enough awareness of them within the prison population?

David Liddell: We are engaged in such work. We were recently involved in a men's health day at HMP Low Moss, and one of the things that we were doing was seeking to raise awareness. It is definitely the case that individuals at risk of and with HCV need improved awareness of the new treatments that are available, which have a high efficacy.

Tom Arthur: Do you agree that stigma is still a big challenge in prisons, as are issues around confidentiality and privacy in relation to testing?

David Liddell: Absolutely. As part of the health visits that we have done, we have picked up individuals who are not disclosing their BBV status. Are you talking specifically about blood-borne viruses?

Tom Arthur: Yes.

David Liddell: Some individuals do not disclose their status for fear of the stigma—that is particularly the case with HIV, but also with HCV.

Miles Briggs: I want to reiterate what Theresa Fyffe said about those who work in the prison health service. When we met some of them last week, I picked up how passionate they are about their nursing role. One of the things that they kept returning to was the lack of a comprehensive clinical information technology system to get access to records, as they would have for other patients. Does the panel have anything specific to highlight on that issue?

Theresa Fyffe: We had thought that as a result of the transfer to the NHS, the prison healthcare service would start to develop some of the common recording practices and so on, but that just did not happen in the same way. Why should the prison health service model be different? Except for the fact that healthcare there is delivered in the prisoner healthcare context, why should the principles of what is provided within a community care or healthcare model be different for prisoners? The aspiration of the transfer was to improve that and for record keeping and the use of technology to enable that improvement. That is what I meant in relation to the out-of-hours work—if you have the technology, you can have protocol-driven support for various treatments that can be delivered by others, rather than having to wait for individuals to arrive. There are all kinds of ways in which you can transform care through that approach.

Sandra Campbell: We have been working with teams to advocate the use of an anticipatory care plan for patients with chronic conditions who are expected to die—or for whom we would not be surprised if they died—within the coming year. That document is the same as the one that we would use for all other patients in Forth Valley and staff are familiar with it. The plan supports communication with the prisoner. Also, we want to avoid an inappropriate admission to hospital, so the plan can act as a communication tool between teams and be beneficial in getting the best outcome for the prisoner.

Miles Briggs: Is that all paper based?

Sandra Campbell: We can do it electronically as well. As part of the Health Improvement Scotland work around anticipatory care planning in the wider context, we are about to test the use of the new documentation. Prisoners are one of the categories that we are about to test.

The Convener: Over the past few weeks, we have heard that there is a general view—it has been held for some time—that we lock up large numbers of people for medical problems rather

than for criminal justice issues. Does anyone disagree with that? No? Well, thank you for your attendance. [*Laughter*.]

Alison Johnstone will disagree with me—go for it, Alison.

Alison Johnstone: Can I ask one final question, convener?

The Convener: Yes, of course, since it is you, Alison.

Alison Johnstone: I believe that the cabinet secretary has suggested a five-year timescale for a move to smoke-free prisons. Perhaps Mr Liddell could comment on that.

David Liddell: You need to speak to Action on Smoking and Health for the detail on that. Certainly, for people with a long-term history of drug problems, smoking is the norm. We have a training programme for people with a history of drug and alcohol problems to train as workers and most of those people continue to smoke even after being in recovery for a lengthy period. For the vulnerable populations that we are talking about, their issues with smoking and how it is dealt with are a big challenge. How it is managed in prisons is a significant issue, as it is in other institutions.

Professor Holloway: I do not know about that issue in particular, but I have a colleague who is doing a piece of work on smoke-free prisons at the moment at the Medical Research Council unit at the University of Glasgow. I am happy to give the committee the details.

The Convener: Perhaps we will move to a smoke-free Parliament at some time, too. I thank everyone for their attendance this morning. It has been much appreciated. We will suspend briefly to allow the panel to leave.

11:46

Meeting suspended.

11:53

On resuming—

The Convener: Under agenda item 3, the committee has an opportunity to discuss the recent informal evidence sessions that have taken place as part of the healthcare in prisons inquiry. Last week, we met prison healthcare staff and this morning we met former prisoners. I thank all those who came along to what were very helpful and informative sessions. We greatly appreciate their time.

I invite comments from members on the themes that have emerged from those meetings and from today's evidence session.

Miles Briggs: I will start on a positive note. At last week's evidence session, I was really taken by what the nurses reported about some of the work that has taken place and some of the reforms that have been put in place. The criticism that they have had does not really pick that up, because a lot of good work is happening, even if the rate of reform is perhaps not what some people would like. From what the nurses told me, the reforms that have taken place have transformed the experience of prisoners in prison currently.

Alison Johnstone: David Liddell, in particular, raised the issue of appropriateness. One of the ex-prisoners I met this morning said that some halls are now like mental health wards. There are issues to do with access to appropriate healthcare and delays, for various reasons—having the staff to accompany prisoners on a healthcare visit can be a barrier.

Clare Haughey: One issue that I picked up on last week, which we touched on a little this week, is that staff's time is not utilised well enough. Dentists in particular said that they had 50 per cent downtime because of the logistics of transferring prisoners from halls to healthcare facilities and because when they have particular groups in, they cannot have other groups in. In the Edinburgh prison, female and male prisoners cannot be in the health centre at the same time, which means that a lot of time is wasted, and healthcare staff have found that frustrating. There is a logistics issue involving healthcare and the SPS that needs to be looked at.

The Convener: The main theme that emerged for me was about what happens when people leave prison. A number of people said that although there are problems with addressing health needs in prisons, generally they get healthcare in the prison setting, but that falls down once they are liberated from prison because of the lack of support. There is supposed to be a system in place to help them to get benefits and housing sorted out and access a GP and any other services that they require, but in many cases the system appears to be falling down—although, in some circumstances, organisations such as Sacro are there to help prisoners on release. Prisoners who did not have that system expressed their frustration about that and about the knock-on effect—being put back into the criminal justice system because they do not have a roof over their head, they do not have money, their health deteriorates and so the circle starts again.

That was not the experience across the board, but it was a general theme that I picked up in my discussions with staff—who expressed their frustration—and prisoners who had been through the system.

Would members like to raise any other issues? We have extensive notes on what we heard, so we will put a lot more on the record.

Maree Todd: I agree with you about that issue. There is also a particular tension between the models of care within and outside of prisons. Last week, we heard a great deal about computer systems not speaking to each other, and it would be remiss if we did not flag that up in our report.

The final thing that I heard a lot about last week was access to not just dental healthcare but the basics that promote dental health, such as sugar-free drinks, particular types of toothbrush, floss and interdental brushes. In many prisons, such things are considered luxuries and there has to be some negotiation around getting them. I would say that promotion of dental health is about healthcare; it is not a luxury.

The Convener: There was also the issue of canteen lists, where prisoners vote on things to go on a list of provisions that they can buy. Healthcare items were on those lists, alongside things such as sugary drinks that would deteriorate prisoners' teeth, and dentists were frustrated by that. However, I suppose that that might be—I say this reluctantly—an issue of democracy in prisons. I know that that is an alien concept, but I think that people will know what I am talking about.

We will capture all that and much more in the notes that we will write up.

11:59

Meeting continued in private until 12:15.

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