ScotPHN report

Scottish Public Health Network (ScotPHN)

Review of Health Care Needs of Prisoners in relation to Throughcare

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The first few hours and days in custody represent a particularly vulnerable time for prisoners newly admitted. The information which accompanies the prisoner on admission contains potentially vital information to assist those with the responsibility of caring for them in that early period in custody. A recurring feature we have highlighted in our reports is that too often important information on the Prisoner Escort Record form is communicated neither to the healthcare staff nor prison officers who are conducting initial assessments on admission at reception. This increases the risk that important information about previous incidents, mental health issues or other vulnerabilities are not passed on to those who need to know.

HM Chief Inspector for Prisons for Scotland: Annual Report 2013-14

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‘*Successful transitions for prisoners in relation to healthcare on (entering and) leaving prison back to the community depend upon on-going, effective and consistent support, good communication and continuity of healthcare. This can have an impact on ongoing health, wellbeing and reoffending.’(NPHN 2012)*

Prison presents an opportunity to address the health and wellbeing of a particularly marginalised group of people. There is evidence to suggest that there is unmet need, with many prisoners who could potentially benefit from healthcare interventions. Yet, as noted by the National Prison Health Network in Scotland, providing an effective health element as part of planned throughcare arrangements is essential to ensuring that these benefits continue beyond prison and become an essential part of the successful reintegration of prisoners.

However, the current arrangements, which provide for statutory throughcare of long-term prisoners and voluntary assistance for those with short-term sentences, do not make a health care assessment a formal requirement within throughcare plans.This rapid health care need assessment demonstrates that this approach creates opportunities for health care needs to be unmet on return to the community. There is also evidence that the current throughcare arrangements are failing to deliver continuity of care for a potentially vulnerable group of people. Not only will this affect health gains which could have been made within the prison environment, but also potentially exacerbate existing health inequalities.

The transfer of the SPS health care services to the NHS in Scotland has been a positive step forward for the health of prisoners, signposting a move toward equitable health care provision. The effectiveness of this move would be enhanced if the agreement to promote prisoner throughcare, set out in the SPS-NHS memorandum of understanding (2011), was now made a requirement so that an assessment of health was fully integrated into the throughcare planning processes to secure greater continuity of care.

Introduction

Prison presents an opportunity to address the health and wellbeing of a particularly marginalised group of people. With regards to institutional arrangements for prison health, the WHO recommends, that:

- managing and coordinating all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility, and
- health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions. (WHO/Europe 2003; WHO/Europe 2007; WHO/Europe 2013)

This has been achieved in Scotland so that the provision of prison health care in Scotland is now under the jurisdiction of the Scottish Government's Health Department and not the Justice Department. The transfer of the Scottish Prison Service health care personnel to NHS Boards in Scotland was completed in November 2011, making NHS Boards responsible, through the provision of healthcare services for those in prisons within their geographical boundaries, for improving the health of prisoner, ensuring equivalence of health services to those available in the community, improving continuity of care on release and reducing professional isolation for prison healthcare staff. It has been reported that NHS Board prison health care services are now running smoothly in the main (NPHN 2012).

During the period since the transfer, changes within the prison estate in Scotland (including the move towards community facing prisons, new prisons opening, new buildings, and the diffusion of women across the prison estate), whilst not necessarily vastly changing prisoner numbers in any particular NHS Board, may present new challenges in terms of skill mix and specific services for certain client groups(NPHN 2012).

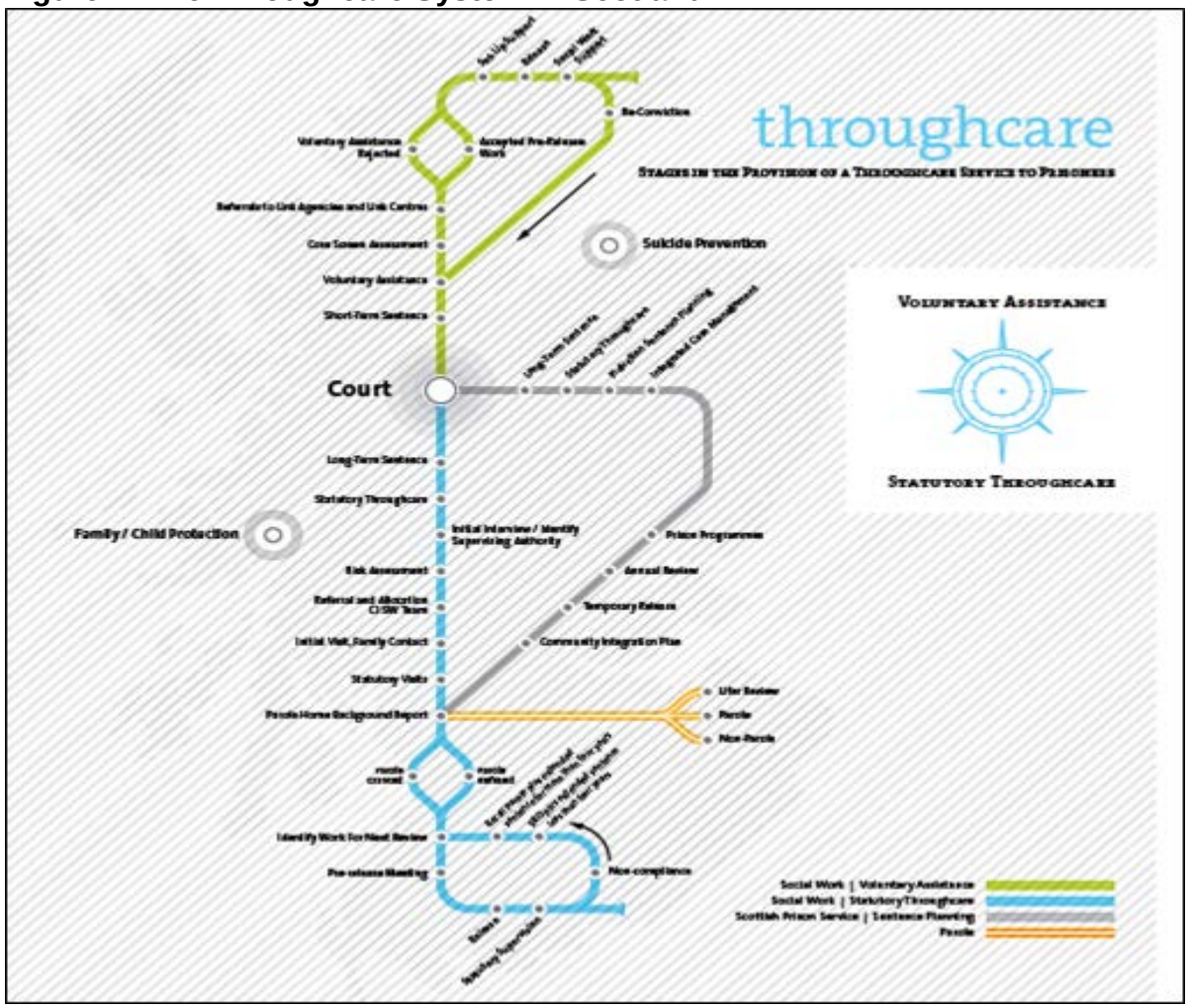
This rapid review of the health care needs of prisoners focuses particularly on the continuity of care for prisoners, i.e. on the throughcare arrangements, recognising that within the health sector, there is a significant evidence base showing transitions between types of service or service settings can be a potential barrier to effective continuity of care, especially where the individual receiving the care may have multiple or complex health and social needs.(Naylor and Keating 2008; Singh 2010). There is evidence suggesting this is also true of transfers from penal care to community services.(MacDonald, Williams et al. 2012; SCCJR 2013).

Current Throughcare Arrangements: NHS Involvement

Throughcare refers to the provision of a range of social work and associated services to prisoners and their families from the point of sentence or remand, during the period of imprisonment and following release into the community. The services have a primary objective of public protection, though they are also concerned with assisting prisoners to prepare for release and helping them to resettle into their community within the law. The overall throughcare process has been mapped by the

Institute for Research and Innovation in Social Science at the University of Edinburgh has mapped the Scottish through care system (See Figure 1).

Figure 1: The Throughcare System in Scotland



The present arrangements for throughcare are complicated, with a division of prison populations into 2 main groups of prisoners (eligible for statutory or voluntary assistance).

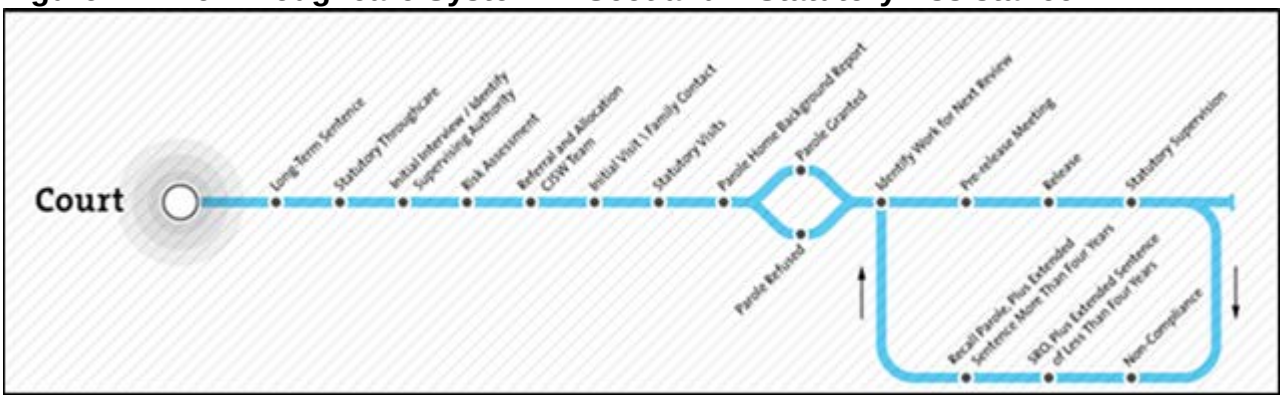
Statutory assistance

Statutory throughcare is provided for long term prisoners[1]. At the end of March 2012, 5,600 individuals were subject to statutory throughcare arrangements in Scotland, with 3200 cases in custody being supervised. In 2011-12, 43 per cent of the cases were being supervised in the community.(Scottish Government 2012)

Figure 2 shows the main elements of statutory throughcare. In general, NHS involvement is not mandatory for this group of prisoners, with the NHS only becoming involved if the prisoner has enduring needs and the prisoner sees it as necessary.

[1] People serving sentences of over 4 years, or serving Extended Sentences or subject to Supervised Release Orders who serve less than 4 years but who are subject to statutory licence on release.

Figure 2: The Throughcare System in Scotland – Statutory Assistance



Voluntary assistance

Voluntary assistance is available to prisoners who receive shorter prison sentences, usually considered to be of over 6 months and under 4 years duration (See Figure 3). Prisoners in this group are not subject to statutory post release supervision but are entitled to request advice, guidance and assistance from local authorities in the twelve months following their release from prison.

In 2011/12, according to Criminal Justice Social Work (CSJW) data, there were some 9658 short-term prisoners (> 6 months to < 4 year sentences) liberated, and some 2600 voluntary assistance cases commenced (a 4% decrease on previous years). In effect, this means that almost three-quarters of prisoners eligible to request voluntary assistance did not request the service., i.e. only 1 in 4 prisoners returning to local communities at best received support from voluntary assistance services (Scottish Government 2012) The number of individuals receiving voluntary assistance in 2011-12 rose slightly to 2,428 individuals, an increase of 3 per cent compared to 2010-11. (Scottish Government 2012)

The priority groups for voluntary assistance are high risk offenders not at present subject to statutory throughcare and offenders eligible for the Throughcare Addiction Service (TAS). There is, in general, no formal requirement for NHS involvement in this process, with one possible exception: where prisoners are referred by the Criminal Justice Social Worker (CJSW) to the substance misuse services provided as part of TAS.

Figure 3: The Throughcare System in Scotland – Voluntary Assistance

The Throughcare Addiction Service (TAS)

The TAS commenced on 1 August 2005 and forms part of the voluntary aftercare provision. It is targeted at people serving over 31 days in prison, and works with service users for the last 6 weeks of the prisoner's sentence and the immediate six weeks after release. At least two face to face meetings with the prisoner will occur pre-release and attendance at the Community Integration Case Conference (CICC) / Community Integration Plan (CIP) meeting. However, where the CICC/CIP suggests there is a need for immediate support, due to risk and vulnerability, then arrangements would be made to meet the person on the day of release at the prison. Generally offenders would be linked into their local Community Addiction Team (CAT) or the Homeless Addiction Team. (Government)

In 2011/12, according to CJSW data, of the 2428 individuals who received voluntary assistance, some 57% (n=1390) were TAS cases.(Scottish Government 2012).

In order to provide the co-ordinated service that is envisaged in legislation, there is a need to ensure closer collaboration between partner agencies, so that policy initiatives can be integrated rather than fragmented and good practice developed which is understood and accepted by all the relevant stakeholders . Yet current arrangements for throughcare services do not prompt for NHS engagement in throughcare assessment processes.

The Integrated Case Management system which has been introduced requires that all prisoners receive a core screen interview on entry to prison. The purpose of this screening tool is to enable support throughout a sentence, and is the primary source for referring to one of the partner agencies. The interview covers issues such as housing, benefits, job advice, resettlement, childcare issues, substance misuse, educational needs and employability. This could provide an opportunity for further NHS and public health engagement.

Conclusion 1:
The current arrangements for statutory throughcare or voluntary assistance for short-term prisoners do not require a health assessment to be undertaken. The lack of a coherent, single system for the management of throughcare militates against effective continuity of health care.

Evidencing Health Care Needs

A rapid health care needs assessment is a tool to review the health issues facing a defined population, leading to the agreement of priorities for action that will improve the health of the population, and reduce health inequalities.

The specific aim of this health care needs assessment is to:

- provide information on the prison population which may require health throughcare in order to plan, negotiate and change services for the better and to improve health in other ways;
- identify unmet health needs among prisoners; and
- build a picture of current health needs that may need to be met to provide continuity of care as part of the throughcare arrangements.

This health care needs analysis utilised a secondary analysis of existing health and justice activity data and on health status data drawn from specific data collection exercises. . These data used focused on the profile of the prison populations and data relating to the prevalence of physical health, mental health, communicable diseases, drug abuse and dental health problems within these problems.

There are two major sources of health status data relating to prisoners in Scotland: The Scottish Prison Service Health Care Need Assessment (Graham 2007); and The most recent Scottish Prisoner Survey (SPS 2013). However an analysis based on these data sets is not an exact science – it can provide no more than an "indicative" description of the health care needs of prisoners that are likely to require sort of care continuity which a health component to throughcare could provide.

The number of short-term prisoners needing throughcare assessments

The majority of prisoners in Scotland are male (94%), young (43% aged under 30), and white (96%). Many are from deprived areas, with approximately 27% of the overall prison population (34% of young offenders' population and 30% of female prisoners) indicating that they had spent time in care. (McCoard 2013). In 2011-12, the average daily prison population was 8,178, an increase of 4% from 7,853 in 2010-11. Of these 1,600 (20%) were on remand, an annual increase of 9%.

Data is not routinely collected that links prisoners at sentencing with the NHS Board responsible for their health care at the time of sentencing (and thus presumably at liberation). To produce a population base for the analyses the number of liberations for short term prisoners in 2011/12 have been analysed and – where possible – a proxy for NHS Board at liberation identified. This provides an estimate of the NHS Boards that would be required to participate in throughcare planning and case management up to, and immediately beyond, liberation (See table 1).

Table 1: Liberations from prison by custody type/sentence length and NHS Boards (proxy) : 2011-12

	Less than 6 months	6 months - less than 1 year	1 year - less than 4 years	All
NHS Ayrshire & Arran	246	317	290	853
NHS Borders	32	36	19	87
NHS Dumfries and Galloway	76	49	62	187
NHS Fife	170	186	175	531
NHS Forth Valley	161	181	139	481
NHS Grampian	201	232	236	669
NHS Greater Glasgow & Clyde	1,059	848	881	2,788
NHS Highland	187	153	86	426
NHS Lanarkshire	349	345	393	1,087
NHS Lothian	282	316	316	914
NHS Orkney	6	8	6	20
NHS Shetland	2	3	7	12
NHS Tayside	305	380	302	987
NHS Western Isles	12	13	4	29
No local connection	219	174	194	587
NHS Scotland	3,088	3,067	2,916	9,071

Identifying Unmet Health Care Needs

Need in healthcare is defined in relation to a patient's ability to benefit from health care (in contrast to demand, which is what patients or professionals ask for, and which may be influenced by other factors such as the supply of a service, or beliefs about its benefits). In effect, this means that there is only a need for healthcare, when the individual has either manifested a problem or runs the risk of manifesting the problem, and there is a treatment which could be made available to respond. Unmet needs therefore refers to identified or identifiable health challenges, for which there is a recognised effective intervention, which is not yet available to the individual manifesting the need.

Identifying unmet needs is difficult. Often the healthcare needs of prisoners and ex-prisoners only become visible to services when there has been a failure to successfully sustain initial liberation arrangements, or a communication breakdown in transferring information on incarceration. The consequences of failure to access health care and loss of continuity of care for mental health[2], substance misuse and chronic disease management can be significant to individuals and their families.
A holistic understanding of the challenges facing an individual can make an enormous difference to people already struggling with adverse life circumstances. Timely access to health services can play a key role in the rehabilitation process, addressing underlying health problems, and supporting ex-prisoners to make positive changes to their lives.

Whilst specific data on unmet need is not available, case studies have been used to illustrate these holistic challenges and the health care needs that can arise. All the case studies are based on real situations described by NHS staff or Third Sector agencies. To preserve confidentiality personal details have been changed.

[2] I CIRCULAR NO: SEJD 12/2002 (Revised May 2004) THROUGHCARE FOR LONG TERM PRISONERS AND PRISONERS SUBJECT TO SUPERVISED RELEASE ORDERS GUIDANCE FOR SOCIAL WORK SERVICES looks at strengthening current throughcare arrangements whilst developing a broader agenda to manage the transition from prison to community more effectively. Whilst health is not explicitly mentioned within this order, it does mention 'prison based specialist staff'. Guidance for Phase 2 in implementing the enhanced throughcare strategy VOLUNTARY ASSISTANCE - Guidance for Phase 2 includes the NHS as a strategic partner, including for mental health, and suggests that participation in health programmes, specifically drugs and alcohol, could be included in a Going Straight Contract

Unmet mental health needs

Case study 1: Jane

Jane, a single parent to a teenage daughter, was referred to The Shine mentoring Service by her Criminal Justice Social Worker. She has a lengthy record for prolific shoplifting offences. Jane has a history of psychosis and other mental health problems. Her life was chaotic – dealing with school bullying, and caring for a severely disabled mother and a brother with a heroin addiction. She admits that she steals to experience emotional highs and says that she is addicted to the feeling of success when she leaves a shop with unpaid goods.

Her Mentor started working with Jane to identify other strategies that could enable her to experience a feeling of wellbeing and together they devised a strategy for avoiding the shopping centre when she felt the desire to steal. A referral was made to a counselling service to enable Jane to discuss her emotions and fears surrounding her brother's addiction and its effect on her. Her Mentor also arranged training in harm reduction so Jane felt more confident in facing situations where her brother has discarded used needles in the family home. Jane hopes in the future that she can access further training to become a Peer Supporter for other families living with addiction. Jane also became an active member of the SACRO Women's Group, providing an opportunity for her to socialise and get support from her peers.

Case study 2: Molly

Molly, a property developer with no previous criminal record, or family support, turned to alcohol as a coping strategy following a family bereavement. The alcohol influenced her offending behaviour, resulting in a legal statutory order for 12 months. She was referred to SACRO's Women's Mentoring Service through Criminal Justice social workers in Fife. Initially she presented to the service as self-loathing, self-harming and had difficulties with confidence, self-esteem and self-belief.

Although Molly had issues with alcohol, she strongly believed she had been misunderstood and that there was an underlying (undiagnosed) issue with mental health which contributed to her actions, complaining of being 'manic' and then very 'depressed'. She also explained that she has a family history of mental health issues as her father had Schizophrenia and passed away due to this.

After around a period of 8 months, in which Molly extensively researched her symptoms, she was given a second opinion by a health professional, resulting in a diagnosis as Bi-Polar in the manic stage. This diagnosis has provided Molly with an understanding of her own actions and acceptance of her behaviour. She has now completed her statutory order, having voluntarily extended her order by 12 months to receive continued support. She is now undertaking voluntary work with Front Line Fife as a befriender, is planning for her future employment, and is continuing her involvement with SACRO as a member of the service user board and as a volunteer.

As these case studies demonstrate, underlying health issues can be masked by adverse life circumstances, resulting in unmet need, and exacerbating already difficult situations.

In 2008, a report on mental health in Scottish prisons reported that:

'*There are a number of gaps in the identification of mental health problems and needs. These include: problems with the transfer of information from courts and the community; difficulties for prisoners in disclosing issues; problems with processes and operational issues; and problems with staff being able to identify issues. These difficulties can mean that some prisoners with severe and enduring mental health problems may not access assessment and referral.'(HM Chief Inspector of Prisons for Scotland 2008)*

Loss of Continuity of Care

Failure to establish robust links with the NHS throughout the throughcare process can result in an avoidable lack of continuity of care for long term treatment of established conditions. Enhanced communication between the prison service, the NHS and voluntary and charitable organisations, such as Families Outside, can play a vital function in both identifying potential causes for health concern for prisoners, and alleviating significant causes of stress in family members.

Case Study 3: David

DAVID suffers from Attention Deficit Hyperactivity Disorder (ADHD), and is Bipolar. Prior to his arrest, he was on medication and under psychiatric care, both of which had been in place for a number of years. Since his conviction, his family were concerned that his access to psychiatric support within the prison had been curtailed, and he was exhibiting signs that suggested to his family that he wasn't taking his medication regularly. Contact was made with the FCO, who agreed to ask an NHS nurse to check on him. Subsequent conversations established that David's medication had been discontinued. Discussions with David's community psychiatrist established that there had been no request for case notes from the NHS within the prison, leaving the family very concerned about David's ongoing long term treatment, and the behavioural issues which are likely to result from the lack of medication.

David's is not an isolated case. Communication is key to ensure that appropriate and timely medical support and treatments are available to prison populations, throughout their prison journey. NHS engagement at an early stage in the Throughcare Process can prevent delays in medical treatment, and reduce added stress to family members, who are already struggling with difficult circumstances.

Case Study 4: Families Outside Cases

Delayed medical treatment

Several members of a Family Addiction Support Service (FASS) group meeting, were looking for a named contact person to officially complain to in regards to the lack of medical treatment that members of their families had experienced when first admitted to prison. The group members reported that their relatives were sometimes having to go 9 -14 days or more without their medication and that they had to witness them in withdrawal during visits. This had been very distressing. The group felt very strongly that this was a deliberate action on the part of the prison despite my explanation that there had been a change of governance from SPS to NHS. They

also said that they had visited their relatives GP to progress this matter, as they had been told by the SPS/NHS that the delay was with the GP, only to be informed (and shown by the GP) that the relevant information had been processed at an earlier date.

Others being supported by the organisation shared concerns about family members not receiving their medication for a range of conditions, including heart problems, deep vein thrombosis, asthma, ADHD, drug addiction, and depression, for several days after their imprisonment. In some cases this had lasted longer than a week.. On the whole, the families had been proactive in their attempts to contact the staff in prison with the relevant information, although this has been met with a standard response stating that this is a GP and NHS issue; SPS staff have generally said that they are unable to comment. This has left family members feeling very frustrated and anxious.

Hospital appointments missed

After having worked in a prison environment for several months now, and dealing with myriad problems and issues, a case worker has found that there are frequent queries and situations regarding the health of new prisoners. One brief incident illustrates the sorts of problems identified.

A lady who had visited over the weekend was very concerned about her partner who had been brought in to the prison just before Christmas and who would have had an appointment at the hospital for a biopsy on his lung. This appointment had not been kept because he was in prison. Cancer was suspected and both the prisoner and his partner were exceedingly anxious about the diagnosis because they had heard nothing since.

The case worker was able to inform the NHS staff who said that the matter was now in hand.

Whilst previous case studies have identified current, potentially systemic barriers to accessing health care services as part of the throughcare process, there may also be significant personal barriers to accessing health services in prisons. Reluctance to raise health concerns can militate against timely access to health care.

Case Study 5: John

John's mother reported that he had been quite unwell (urinary tract infection) recently, and there was a significant delay in him receiving medical attention (3 – 4 weeks), by which time her son was in considerable pain because his infection was severe. He was on a course of antibiotics, although his pain and discomfort had not cleared. The mother was very angry and upset that her son had not received the basic medical treatment he required and felt that this was because of the nature of his crime. She discussed this with her son, and he informed her that there is no point in him complaining as this will only result in him being put on report and labelled as a trouble-maker. Her son had been told her that he just wants to keep his head down and get through his sentence.

Case Study 6: NHS Board Keep Well & Through care

The KeepWell programme run by an NHS Board in Scotland, aimed to engage with prisoners in prison and on liberation. They experienced significant problems in reaching its target audience. Whilst links were made to local Prisons, the relevant Criminal Justice Social Work Departments, and to partner organisations, (e.g. Routes out of Prison, Attigo, APEX, SACRO), internal issues in the prison which held the majority of short term prisoners meant that the KeepWell service was not able to operate within the prison. The KeepWell team met with Life coaches from Routes out of Prison (ROOP) to try and engage with offenders on liberation. However, this route had limited success, with only 2 referrals received by the team. Requests through other routes asking for referrals by phone were unsuccessful. .

Prison health checks, once established in prisons, resulted in three referrals that required case management or other KeepWell interventions. However, these referrals were received several weeks after the people were liberated from prison and after numerous attempts to contact these individuals, information was received that two people were back in prison and the other was no longer living within the NHS Board's area and was not contactable at the given address.

The KeepWell team opportunistically met with a man who had been liberated from Prison five days earlier, and had been sleeping rough over a bank holiday weekend. After presenting himself as homeless at a police station, he had been accommodated at a homeless unit. The man had been liberated with nowhere to stay, no access to food, very little money, and no registered GP or social network. Following his KeepWell health check he was referred to the Health & Homeless team for support.

Case study 7: Derek

Derek, an older prisoner over the age of 60, was released from prison into local authority flat on a Friday. By the following morning he had been found on the floor of his flat, unable to get up, by his case worker. He was admitted to hospital and his health care needs assessed. He was released back to his flat having no specific reason to keep him at in hospital and a referral was made for a community follow up. This did not happen as Derek was found on the floor again on the Sunday afternoon. He remained in hospital for several weeks as he remained sufficiently well enough to go home, but unable to do so as social services and his case worker felt it to be unsafe to discharge him. The deadlock was only broken when a delayed discharge was declared and the situation fully reviewed.

The local NHS and Social Work department reviewed the case and found a number of factors which meant the situation had been predictable. At its heart was the fact that Derek had multiple needs, including cognitive deficits and low capacity for self-care. These needs had been met by his cell-mate who had acted as an unrecognised, informal carer. The throughcare arrangement had not sought a full single shared assessment, which would have highlighted the complexity of his need. An occupational therapy assessment was requested to see if he could cope in a flat, but this did not happen as the prison was not prepared to allow even the use of the training kitchen for that purpose. As a result, Derek was liberated to a second floor flat; in a building with no lift and no household adaptations to support his limited mobility and self-care skills.

Throughcare assessments *should* provide an opportunity to identify and negotiate access to other services, which can support individuals already facing challenging circumstances. Without a formal requirement for a throughcare assessment to include health care needs, the ability to even negotiate an effective single shared assessment on this prisoner coming back into the community meant they were housed in an unsafe environment, without appropriate care and very quickly the placement failed and they needed hospitalisation.

The current process for registration of prisoners for health care requires that after 6 months the prisoner is fully registered with the Prison Practice for their health care and deregistered from the community practice. Prisoners serving a sentence in excess of six months would therefore have to actively re-register with a community practice on release. Prisoners with a sentence of less than 6 months can be registered as a permanent patient with prison health services if the Prison thinks it appropriate to do so clinically, i.e. if the patient has significant health issues that may require the records to be accessed.

NHS Boards are looking at ways to ensure throughcare is continued when patients leave prison, quite often by setting things up with a GP Practice so liberated prisoners are able to quickly register on release. If this is not in place for a liberated prisoner they can approach a GP Surgery of their own accord, or PSD can assign them a practice. Access to healthcare can be a particular problem for people who have not been formerly released from prison and therefore cannot register as a permanent patient with a Community GP Practice (all patients can only be registered in one place at a time) and cannot go back in to prison to get healthcare/medication.

Recent data, provided by National Services Scotland in May 2014, suggest that the majority of patients have been able to secure registration with a GP practice on release (see table 2). However, there is some anecdotal evidence that prisoners within the prison system (particularly those serving long sentences) may face particular challenges in relation to access to national screening programmes[3].

Table 2:

Patients released from prison but not registered with a GP Practice				
	Released 2012	Released 2013	Released 2014	Total
Back in prison	0	1	3	4
Deceased	0	2	0	2
Moved to England	0	3	3	6
Unregistered	9	25	5	39
Registered*	0	3	0	3
	9	34	11	54

*these are patient who registered after the data was collected

[3] L Graham – person communication, 16 April 2014

Conclusion 2:
What evidence does exist suggests that, even where a form of health throughcare for short term prisoners has been running, without active support some prisoners are unlikely to be able to reconnect with health care services provided through primary care services.

Identifying Continuity of Care Needs

"Prisons are not typical environments: indeed they hold quite atypical populations, with significantly higher concentrations of both physical and mental illnesses than the general population. Many misuse substances and suffer considerable social exclusion. In other words the 'typical' need in prison is a multiple one. For this reason careful consideration needs to be given to how the term equivalence is understood and applied. If it leads to simply replicating general community models of health care provision in prison then these are not likely to address this multiple need."(Dorcan 2008)

The foregoing analysis has demonstrated that there is unmet need for support by health services within prisoner and ex prisoner populations, which could be addressed by more systematic engagement of the NHS throughout the Throughcare system.

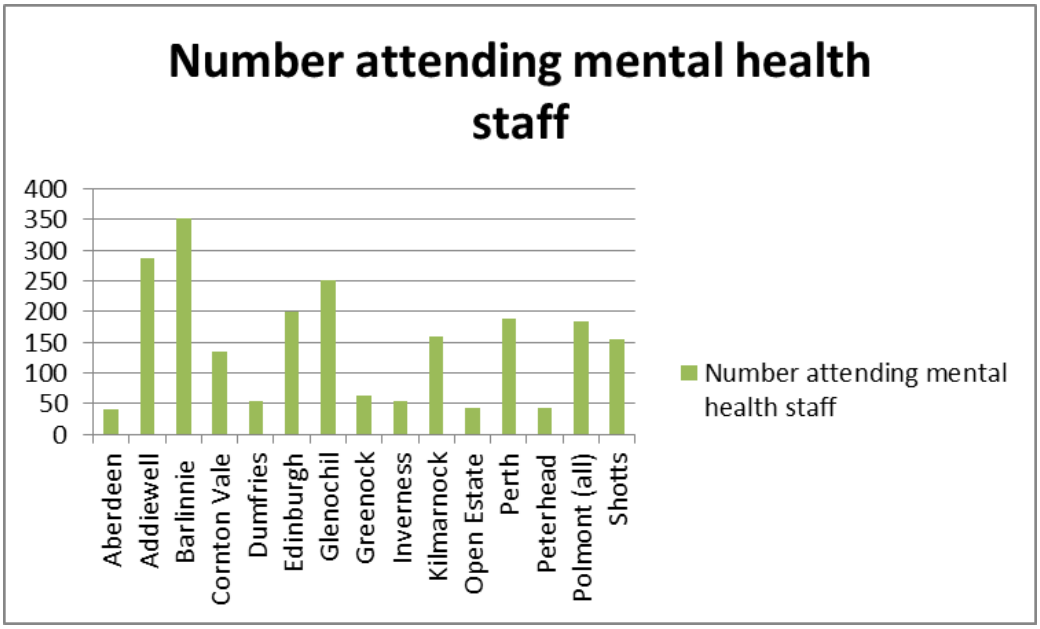
However, there is also a need to identify the scope and scale of the health challenges for which support should be provided, i.e. the potential workload for the health services. This section draws together data to describe a range of health-related conditions. The conditions were chosen as representing problems which the evidence shows are both serious and prevalent in the prisoner population and most likely to require a form of throughcare to provide necessary continuity of care

The prevalence figures have been taken from the needs assessment carried out in 2007, and supplemented by the most recent data on self-reported health from the 2013 SPS prison surveys. This report has therefore utilised two types of data, linking data on health seeking behaviours from the 2013 surveys with data on diagnosed conditions from the 2007 needs assessment, to proxy the number of people who may require a throughcare assessment, and access to relevant health care services. The data therefore provides an estimate of the scope and scale of health issues within the Scottish prison population, based on prison populations, rather than exact data. In effect, this report has performed a secondary analysis of existing data to estimate the potential workload associated with each of the health conditions, i.e. the number of prisoners for whom throughcare may be needed, and the numbers who might already have been assessed.

Mental Health

Mental health issues are commonly reported amongst prison populations. As the Scottish Prison Survey data demonstrates, many prisoners may require a mental health assessment as an integral part of throughcare arrangements, to ensure they are given appropriate support throughout their prison journey. Self-reports from the Scottish prison surveys suggest that 14% of the prison population responding to the survey reported never feeling optimistic about the future, with a further 16% reporting rarely feeling optimistic. (carnie 2013) In total, 27% of survey respondents reported having met with mental health staff. (carnie 2013) Figure 1 shown how these attendances translate into estimated numbers of cases across the whole of the Scottish Prison Estate who may require mental health throughcare.

Figure 1 Estimated number of prisoners for whom throughcare may be needed for mental health issues

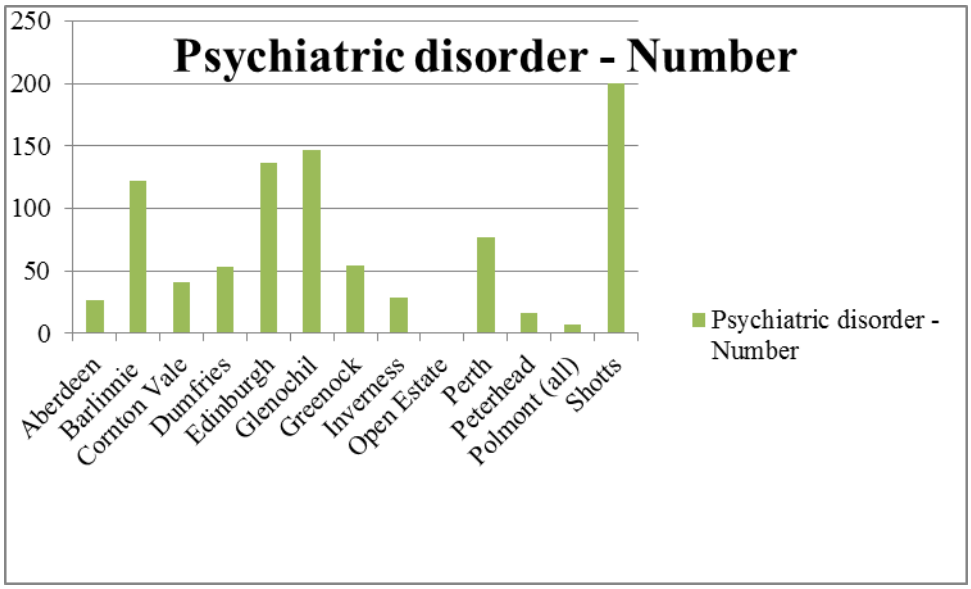


Data Sourced from: Prevalence: Graham 2007; Population: Daily population by SPS establishment adjusted for changes where possible – so not an exact match. NB full data in appendix (table 1)

In Aberdeen, for example, 41 prisoners might be expected to meet with mental health staff, assuming that the prison population is static at roughly 1 in 5 of the prison population (n=241). Numerically, nearly half of the prison population of Cornton Vale could be attending mental health staff (136/289 prisoners), and for Addiewell high numbers may be expected to require mental health throughcare. Mental health problems can be challenging for people to face, and it is possible that this underestimates the potential workload.

A small proportion of prisoners have severe and enduring mental health problems (HM Chief Inspector of Prisons for Scotland 2008), and may require access to ongoing mental health services. Figure 2 shows the estimated numbers of prisoners by prisons across Scotland for whom mental health care services may be needed on liberation.

Figure 2: Estimated number of prisoners for whom mental health services may be needed



Data Sourced from: Prevalence: Graham 2007; Population: Daily population by SPS establishment adjusted for changes where possible – so not an exact match. NB full data in appendix (table 2)

The data analysed for this report did not separate out the data by population group. However, the Commission on Women's Offenders reported that;

'very *many if not most women in the criminal justice system have poor mental health even though they may not require psychiatric management. Interventions, support, environment, relationships and culture can all influence mental health and well-being. Mental well-being should be addressed in all our plans and management of female offenders. The NHS has a key role in working with the justice system to promote this'(Offenders undated)*

A report by the Sainsbury's Centre for Mental Health directly addresses the challenges facing prisoners with mental health issues. It recommends that greater integration of agencies working on health, mental health, substance abuse and resettlement is required to adequately support prisoners throughout their prison journey(Dorcan 2008).

Substance misuse

The relationship between drugs, alcohol and crime has been well documented elsewhere. The 2007 HCNA suggested there was a need for better integration between healthcare and substance misuse specialist services both within the prison estate and en route into and out of prison.(Graham 2007)

Drug misuse remains a major factor in prisoner health statistics in Scotland, with high reported rates of being under the influence of drugs at the time of offence reported in both young offenders (49%) and adult offenders (38%). 62% of all survey respondents (79% of young offenders) reported used drugs in the 12 months prior to coming into prison. Cannabis (78%), benzodiazepams (58%), and cocaine (51%) were the most commonly used drugs. (carnie 2013) Concerns about drug taking being a problem on release into the community were expressed by 21% of prisoners (16% of young offenders, 64% of repeat offenders (over ten times in

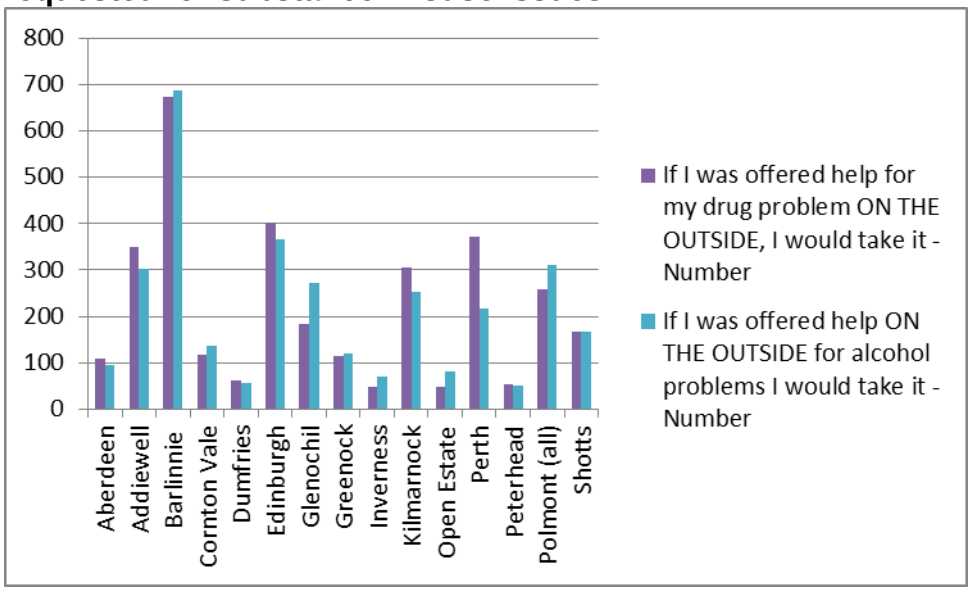
prison), 48% of prisoners who had been in care, 25% of military veterans),(McCoard 2013)

A 2010 HCNA of alcohol in prisons suggested 45% of prisoners are likely to have an alcohol problem on admission to prison (as defined by two or more positive answers to the CAGE questionnaire) (Parks 2010). The Prison Surveys in 2012 showed that recognition of having an alcohol problem is particularly marked in repeat offenders (31% of people who had served over ten sentences reported concerns, as opposed to 12% of people who had never been in prison before), with 30% of this group admitting that drinking had affected their ability to hold down a job, and 41% (versus 26%) reporting that alcohol had affected their relationships with their family. (McCoard 2013)

Respondents were asked to comment on their experience of support for substance misuse. A quarter of young offenders (27%) said that they have been given the chance to receive treatment for drug use during their sentence, with 16% stating that they have received treatment (compared to 28% adults). Percentages for young offenders being offered, assessed and undertaking drug treatment were considerably lower when compared to the adult population (McCoard 2013).

Questions about the willingness to access support for drug and alcohol problems on release suggested high levels of interest – particularly in Addiewell, Kilmarnock and Perth where over half the prison population responded positively to the offer. Figure 3 shows the estimated numbers of individual who may seek assistance for substance misuse if the levels of interest shown within prisons translated into throughcare requests (see Figure 3). Three in ten young offenders said that if they were offered help for their drug problem on the outside (30%) or in prison (34%) they would take it.(McCoard 2013) Two thirds (65%) of male prisoners who served 'over 10 sentences' reported that if they were offered help for their drug problem both outside prison and in prison that they would take it compared with a fifth of those who had 'never' served a sentence (20% and 18% respectively).

Figure 3 - Estimated number of prisoners for whom throughcare would be requested for substance misuse issues



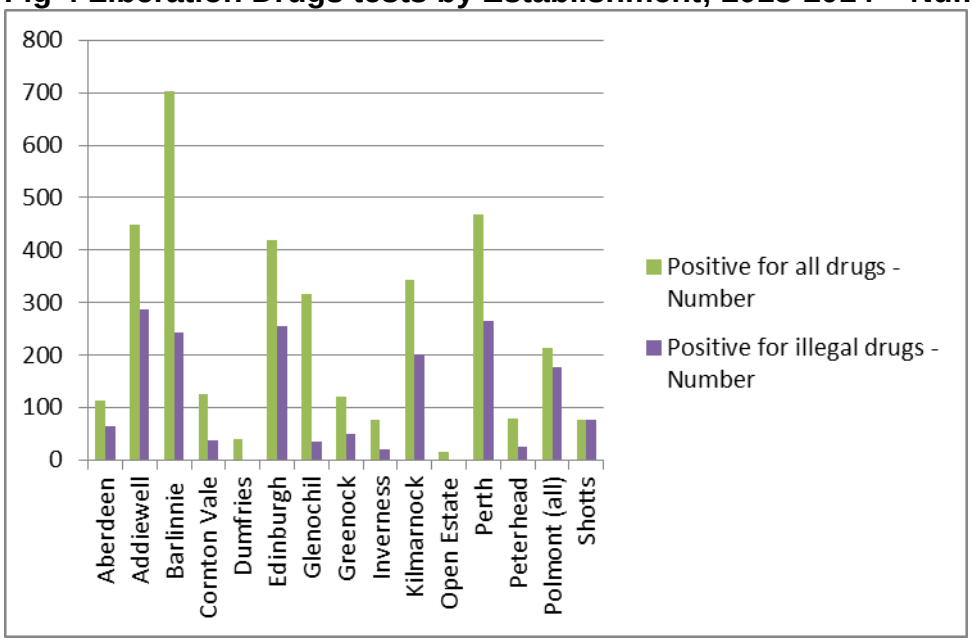
Data Sourced from: Prevalence SPS 2013; Population: Daily population by SPS establishment – so not an exact match. NB full data in appendix (table 3)

Across the prison estate, some 3261 individuals expressed the view that they would accept help for their drug problem on the outside, and for alcohol, 3181 people indicated they would accept help if offered (see Data Appendix, Table 3). In terms of numbers, In Addiewell (348 and 302/774), Kilmarnock (304 and 254/634), and Perth (370 and 217/699) the numbers account for approximately half their prison populations. This is a significant number of people who could potentially benefit from a throughcare assessment to ensure appropriate support is place to build on their readiness to change.

Addiction Prevalence Testing (APT) was introduced in Scottish prisons in 2007 to evidence progress and distance travelled towards the Offender Outcome of 'reduced or stabilised substance misuse'. A 5% sample of all prisoners arriving in custody are tested twice a year for the prevalence of illegal drugs. Similarly, 5% of those leaving custody are randomly tested for drugs to assess the positive impact of addictions programmes. These tests are designed to support measurement of SPS's progress in achieving a reduction in the number of prisoners testing positive for drug use on entry compared with exit. Prisoners are tested at other times during their sentence to support their participation in addictions programmes and prescribing, or to inform other operational decisions

According to 2013 survey data, published by ScotPHO, 72% of prisoners tested positive for illicit drugs on reception (31% of prisoners tested positive for opiates) in 2012/13. On liberation, 23% tested positive for illicit drugs (4% of prisoners tested positive for opiates.[4] A large number of prisoners are testing positive for drugs on liberation across the prison estate. (3566 people for all drugs; 1748 for illegal drugs, see data appendix table 4.).

Fig 4 Liberation Drugs tests by Establishment; 2013-2014 – Number of cases



Data Sourced from: Prevalence Liberation Drugs tests by Establishment; 2013-2014; Population: Daily population by SPS establishment – so not an exact match. NB full data in appendix (table 4)
NB Low Moss excluded

[4] Unpublished Scottish Prison Service Data for 2013/14.

Health Improvement

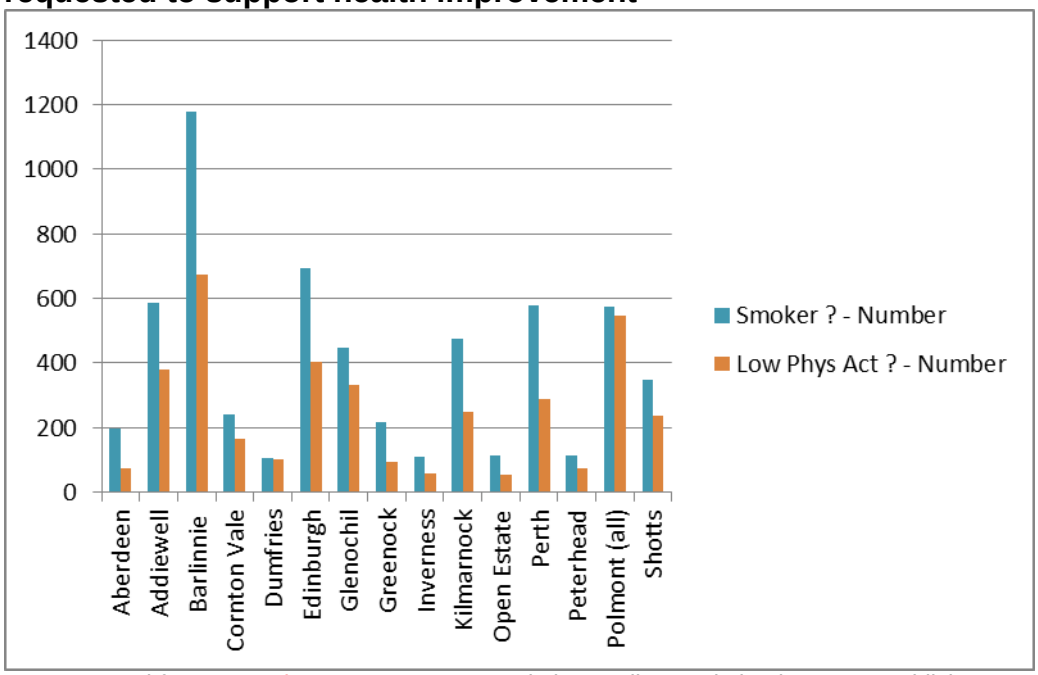
Access to nursing staff within prisons varies greatly by sex and age. A higher percentage of female than male offenders reported accessing nursing staff (85%) and doctors (74%), while less than a half (43%) had accessed mental health staff and had used the services of a dentist (43%) while in prison. A higher percentage of older prisoners reported accessing the doctor (87%) and nurse (83%) compared to those prisoners who were aged under 50 years of age (80%).(Broderick 2014) Significantly fewer young offenders reported accessing doctors (53%) compared to adults (83%). (McCoard 2013)

A number of studies have suggested that the ability to make healthy choices in prisons can be constrained by the routines, regime, and physical limitations of being in prison, perceptions of smoking and other unhealthy behaviours as coping mechanisms, and responses to social interactions with other prisoners.(Sharp 2011) An evaluation report on the KeepWell programme in Lothian, which reported on its first six months of its operation, noted that over a third (38%) of prisoners who had received a health check from the KeepWell team were given a referral to a specific service, but this varied by prison, age and by gender of prisoners:

- those aged 55 and over were likely more than younger prisoners to have been referred to other services; and
- some 40% of male prisoners were referred to other specialist services compared with 22% of the female prisoners.(Sharp 2011)

The SPS survey data demonstrates that there are high levels of smoking and low physical activity rates reported across the prison estate in Scotland. Figure 4, estimates the number of individuals who may need throughcare referrals if the self-reported smoking status and physical activity levels translated into requests for assistance with the behavioural challenges health improvements pose.

Figure 4 - Estimated number of prisoners for whom throughcare would be requested to support health improvement



Data Sourced from: Prevalence SPS 2013; Population: Daily population by SPS establishment – so not an exact match. NB full data in appendix (table 5)

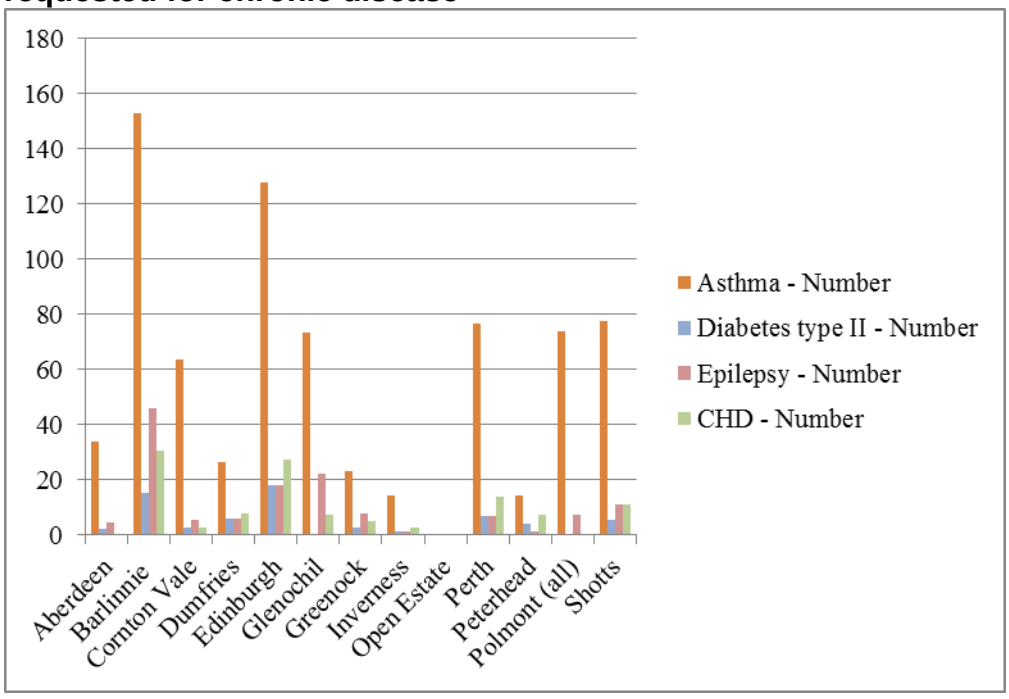
The Scottish Prison Surveys established that three quarters of all prisoners said they smoked (75%), with 60% wanting to give up.(McCoard 2014) The rates of smoking varied across population groups, with prisoners who had experienced greater numbers of sentences being more likely to smoke (60% of the 'never' group, 74% of the '1-5 times group', 86% of the '6-10 times group' and 89% of the 'over 10 times' group were smokers). (McCoard 2013) Three quarters of young offenders (75%) reported that they smoked and half (54%) of those reporting expressed a desire to give up smoking. Six in ten ethnic minority and foreign national prisoners (60%) reported that they smoked and a similar percentage (55%) expressed a desire to give up smoking.(Carnie 2012)

Whilst this suggests there is a high potential workload associated with these particular behavioural challenges, it is also worth noting that, given the high levels of multiple needs within prison populations described elsewhere, it is possible that initial consultations on smoking and physical activity could lead to the identification of other health needs, once contact has been established.

Chronic diseases

Figure 6 estimates the number of prisoners who would require support to ensure continuity of care for diagnosed chronic conditions (asthma, diabetes, epilepsy and CHD) across the prison estate. Asthma was the most commonly occurring diagnosed condition, with an estimated 758 individuals; with an estimated 66 diabetics, 139 Epileptics, and 117 people with CHD. Asthma and type 1 diabetes are known to be more common in younger people, but no data was available on their prevalence in Addiewell prison, which houses a high number of younger offenders therefore it is likely that these figures are an under representation of the potential workload. The 2007 needs assessment of prison health in Scotland suggested that observed rates of asthma in Scottish prisons were higher than would be expected, with a degree of under treatment for this chronic condition .(Graham 2007)

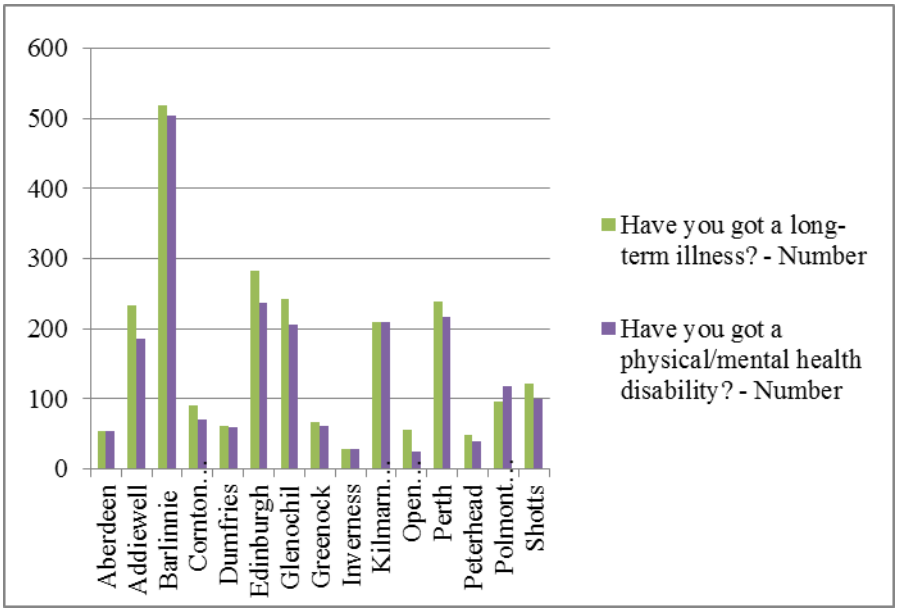
Figure 6 - Estimated number of prisoners for whom throughcare would be requested for chronic disease



Data Sourced from: Prevalence: Graham 2007; Population: Daily population by SPS establishment adjusted for changes where possible – so not an exact match. NB full data in appendix *table 6

Data on self-reported disability (mental and physical, and long term illness has been used as a proxy to determine the number of prisoners for whom a single shared community assessment might be appropriate. Across the prison estate, it has been estimated that some 2344 people suffer from a long term illness, with 2111 people reporting a physical or mental disability. This demonstrates that there are likely to be a large number of prisoners within the current Scottish estate who could benefit from a community single shared assessment as part of throughcare arrangements. As the Lothian case study describes, where such assessments are not conducted, the consequences for individuals can be significant. Perhaps unsurprisingly, Scottish Prison survey data suggests a greater number of older prisoners reported having a long-term illness (46%) compared to prisoners under the age of fifty (27%). (Broderick 2014)

Figure 6 - Estimated number of prisoners for whom throughcare could include an Single Shared Assessment



Data Sourced from: Prevalence SPS 2013; Population: Daily population by SPS establishment – so not an exact match. NB full data in appendix table 7

Summary

Given the nature of the data it is difficult to be precise BUT these estimates suggest that if only 1 in 4 short-term prisoners are requesting voluntary assistance, it is likely that a lot of health needs which could benefit from improved continuity of care are being missed under the current arrangements.

Conclusion 3:
The health status of short term prisoners is poor. Mental health and substance misuse issues predominate, though chronic health conditions are also present amongst prisoners. There is a clear need to ensure any health gains achieved whilst in prison are not lost on liberation due to a lack of continuity of care.

Conclusion

Prison presents an opportunity to address the health and wellbeing of a particularly marginalised group of people. As this review has demonstrated, there is evidence to suggest that there is unmet need, with many prisoners who could potentially benefit from healthcare interventions being missed. The planning and development of current throughcare arrangements is an important mechanism for identifying, screening, and targeting interventions to meet the needs of the prison population throughout their prison journey and transition back to the community. This analysis has shown that the current provision is failing to meet existing health care needs as a result of poor continuity of care. This will not only affect health gains which could be made within the prison environment, but also could potentially exacerbate existing inequalities.

The integration of the SPS and NHS prison health care services has been a positive step forward for the health of prisoners, signposting a move toward equitable health care provision for a marginalised group of people. However, the effectiveness of this move could be enhanced by ensuring the NHS is fully integrated into throughcare planning processes to promote and secure greater continuity of care for the whole of the prisoner's journey.

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Data Appendix

Table 1: Self-Reported Mental Health Attendance

Fig 1			
(All %)		Mental Health	
N	ESTABLISHMENT	During your time in this prison, on this sentence I attended mental health	Number attending mental health staff
241	Aberdeen	17	41
774	Addiewell	37	286
1528	Barlinnie	23	351
289	Cornton Vale	47	136
203	Dumfries	27	55
913	Edinburgh	22	201
736	Glenochil	34	250
257	Greenock	25	64
144	Inverness	38	55
634	Kilmarnock	25	159
267	Open Estate	16	43
699	Perth	27	189
146	Peterhead	29	42
737	Polmont (all)	25	184
555	Shotts	28	155

Data Sourced from: Prevalence: Graham 2007; Population: Daily population by SPS establishment adjusted for changes where possible – so not an exact match

Table 2: Psychosis

N	ESTABLISHMENT	Psychiatric disorder	Psychiatric disorder - Number
241	Aberdeen	11	27
1528	Barlinnie	8	122
289	Cornton Vale	14	40
203	Dumfries	26	53
913	Edinburgh	15	137
736	Glenochil	20	147
257	Greenock	21	54
144	Inverness	20	29
267	Open Estate	0	0
699	Perth	11	77
146	Peterhead	11	16
737	Polmont (all)	1	7
555	Shotts	36	200

Data Sourced from: Prevalence: Graham 2007; Population: Daily population by SPS establishment adjusted for changes where possible – so not an exact match

Table 3: Drugs and Alcohol Support

N	ESTABLISHMENT	If I was offered help for my drug problem ON THE OUTSIDE, I would take it	If I was offered help ON THE OUTSIDE for alcohol problems I would take it	If I was offered help for my drug problem ON THE OUTSIDE, I would take it - Number	If I was offered help ON THE OUTSIDE for alcohol problems I would take it - Number
241	**Aberdeen**	45	39	108	94
774	**Addiewell**	45	39	348	302
1528	**Barlinnie**	44	45	672	688
289	**Cornton Vale**	41	47	118	136
203	**Dumfries**	31	28	63	57
913	**Edinburgh**	44	40	402	365
736	**Glenochil**	25	37	184	272
257	**Greenock**	45	47	116	121
144	**Inverness**	33	48	48	69
634	**Kilmarnock**	48	40	304	254
267	**Open Estate**	18	30	48	80
699	**Perth**	53	31	370	217
146	**Peterhead**	37	35	54	51
737	**Polmont (all)**	35	42	258	310
555	**Shotts**	30	30	167	167

Data Sourced from: Prevalence SPS 2013; Population: Daily population by SPS establishment – so not an exact match.

Table 4: Positive drug testing

N	ESTABLISHMENT	Positive for all drugs	Positive for illegal drugs	Positive for all drugs - Number	Positive for illegal drugs - Number
241	**Aberdeen**	47	27	113	65
774	**Addiewel**	58	37	449	286
1528	**Barlinnie**	46	16	703	244
289	**Cornton V**	44	13	127	38
203	**Dumfries**	20	0	41	0
913	**Edinburgh**	46	28	420	256
736	**Glenochil**	43	5	316	37
257	**Greenock**	47	20	121	51
144	**Inverness**	54	15	78	22
634	**Kilmarnoc**	54	32	342	203
267	**Open Esta**	6	0	16	0
699	**Perth**	67	38	468	266
146	**Peterhead**	55	18	80	26
737	**Polmont (**	29	24	214	177
555	**Shotts**	14	14	78	78

Data Sourced from: Prevalence Liberation Drugs tests by Establishment; 2013-2014; Population: Daily population by SPS establishment – so not an exact match.

Table 5: Physical Activity and Smoking

N	ESTABLISHMENT	Are you a SMOKER?	If YES, do you want to give up smoking?	Less than 5 times A WEEK, of 30 MINUTES MODERATE EXERCISE?	Smoker ? - Number	Low Phys Act ? - Number
241	**Aberdeen**	82	72	31	198	75
774	**Addiewell**	76	63	49	588	379
1528	**Barlinnie**	77	63	44	1177	672
289	**Cornton Vale**	83	39	57	240	165
203	**Dumfries**	52	54	50	106	102
913	**Edinburgh**	76	53	44	694	402
736	**Glenochil**	61	60	45	449	331
257	**Greenock**	84	56	37	216	95
144	**Inverness**	75	66	41	108	59
634	**Kilmarnock**	75	60	39	476	247
267	**Open Estate**	43	83	20	115	53
699	**Perth**	83	63	41	580	287
146	**Peterhead**	78	53	52	114	76
737	**Polmont (all)**	78	54	74	575	545
555	**Shotts**	63	64	43	350	239

Data Sourced from: Prevalence SPS 2013; Population: Daily population by SPS establishment – so not an exact match.

Table 6: Chronic conditions

N	ESTABLISHMENT	Asthma	Diabetes type II	Epilepsy	CHD	Asthma - Number	Diabetes type II - Nu	Epilepsy - Number	CHD - Number
241	**Aberdeen**	14	1	2	0	34	2	5	0
1528	**Barlinnie**	10	1	3	2	153	15	46	31
289	**Cornton Vale**	22	1	2	1	64	3	6	3
203	**Dumfries**	13	3	3	4	26	6	6	8
913	**Edinburgh**	14	2	2	3	128	18	18	27
736	**Glenochil**	10	0	3	1	74	0	22	7
257	**Greenock**	9	1	3	2	23	3	8	5
144	**Inverness**	10	1	1	2	14	1	1	3
267	**Open Estate**	0	0	0	0	0	0	0	0
699	**Perth**	11	1	1	2	77	7	7	14
146	**Peterhead**	10	3	1	5	15	4	1	7
737	**Polmont (all)**	10	0	1	0	74	0	7	0
555	**Shotts**	14	1	2	2	78	6	11	11

Data Sourced from: Prevalence: Graham 2007; Population: Daily population by SPS establishment adjusted for changes where possible – so not an exact match

Table 7: Long term conditions

N	ESTABLISHMENT	Have you got a long-term illness?	Have you got a physical/mental health disability? - Number	Have you got a long-term illness? - Number	Have you got a physical/mental health disability? - Number
241	**Aberdeen**	22	22	53	53
774	**Addiewel**	30	24	232	186
1528	**Barlinnie**	34	33	520	504
289	**Cornton V**	31	24	90	69
203	**Dumfries**	30	29	61	59
913	**Edinburgh**	31	26	283	237
736	**Glenochil**	33	28	243	206
257	**Greenock**	26	24	67	62
144	**Inverness**	19	19	27	27
634	**Kilmarnoc**	33	33	209	209
267	**Open Esta**	21	9	56	24
699	**Perth**	34	31	238	217
146	**Peterhead**	33	27	48	39
737	**Polmont (**	13	16	96	118
555	**Shotts**	22	18	122	100

Data Sourced from: Prevalence SPS 2013; Population: Daily population by SPS establishment – so not an exact match.

ScotPHN report

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