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Understanding the Health Needs of Scotland's Prison Population: A synthesis report

HEALTH AND SOCIAL CARE

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The Scottish Government

Health and Social Care

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Executive summary

It is widely recognised that many individuals in prison experience poor mental and physical health and have a range of needs that are often multiple and complex. The last national assessment of health and care needs of Scotland's prison population was carried out in 2007. Since then there have been major changes to how health care is delivered in Scotland's prison and changes to prison population demographics.

In 2020 the Scottish Government, in collaboration with stakeholders, embarked on a programme of research to provide a more up-to-date picture of the health and social care needs of Scotland's prison population; in order to ensure the most appropriate services are in place to support individuals in prison.

Four pieces of research were commissioned to look at different domains of health: social care; mental health; substance use; and physical health. These studies use prevalence and lived experience data to assess health needs and identify specific recommendations to improve health and care provision in Scotland's prisons.

The purpose of this synthesis report is to draw out the *common themes and interconnections* in the issues and recommendations presented across the four commissioned pieces of research. It is important to note that the issues and recommendations highlighted here do not, therefore, cover every individual recommendation made in each report. This report is not a full summary but rather an analysis of commonality and should therefore be considered alongside the individual research reports to gain a complete picture of health and social care needs.

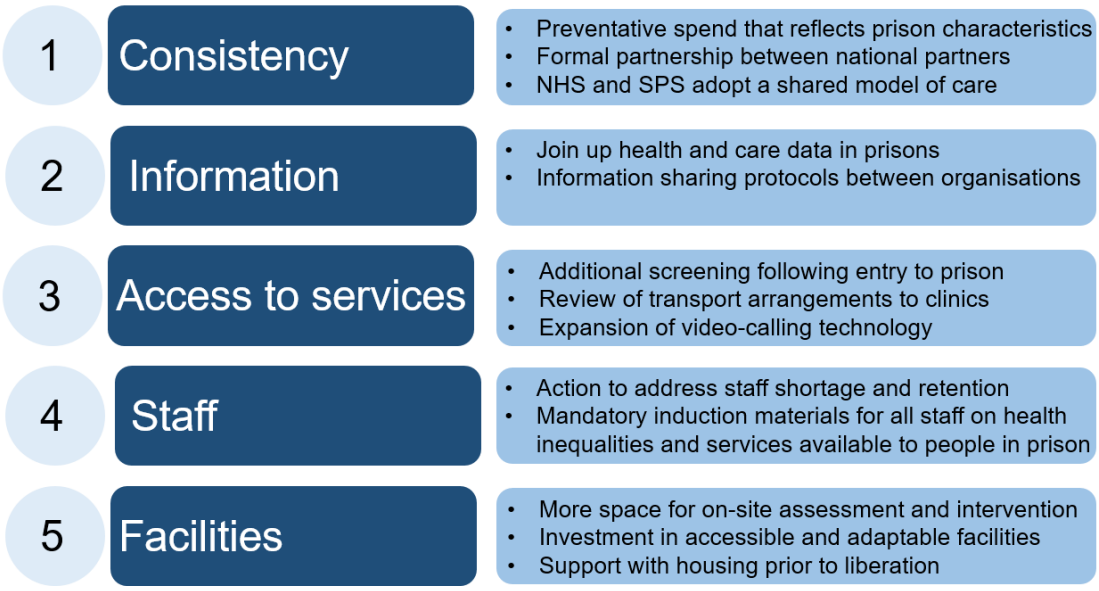
The wide ranging recommendations, which arise from the entire research programme, are also shown in Annex A. An Easy Read version of this report is also available online.

Key findings

All four reports describe a high level of health and social care needs among Scotland's prison population. They also note a high level of comorbidity (having more than one mental health, physical, social care or substance use related need), and identify that some subgroups in the prison population, for example, people on remand and older age groups, have particular needs.

Five common themes were identified across the four pieces of research which comprised the health and care needs assessment. Specifically: consistency; information; access to services; staff; and facilities. A summary of the themes and recommendations, which are detailed in this report, are shown in Figure 1.

Figure 1: Summary of key themes and recommendations



Overall, this synthesis report highlights recent improvements in health and care provision to meet the needs of Scotland's prison population, including the expansion of multi-disciplinary mental health teams in prisons, reports of good relationships between NHS and the Scottish Prison Service (SPS), and the availability of training for health care staff. Another positive development is the increased accessibility of secondary care appointments through greater video-calling capabilities in prisons, a consequence of the Covid-19 pandemic restrictions.

However, across the research it is clear that the health and care needs of Scotland's prison population are significant. Covid-19 has exacerbated long-standing issues of staff shortage and retention in Scotland's prisons. Poor data quality hinders an ability to monitor and respond to health inequalities in the prison population in Scotland. In addition, difficulties sharing information between organisations, a lack of national consistency in health and care provision, and facilities ill-suited for people with disabilities or with care needs, remain key challenges to meeting the health and care needs of Scotland's prison population.

Introduction

It is essential to understand the health and social care needs of the prison population in Scotland in order to improve health outcomes for the prison population and therefore support a reduction in heath inequalities. NHS Scotland subscribes to the principle of 'equivalence' meaning that people in prison should have access to the same level, range and quality of healthcare as that provided in the community, proportionate to need. In both contexts, efforts to improve the provision of health and care services should be evidence-based to ensure effectiveness.

In Scotland, the last national assessment of health care needs in prisons was carried out in 2007.[1] There have been significant developments in healthcare planning and delivery in prisons since then. A key change was the transfer of responsibility for health care delivery in Scotland's prisons from the Scottish Prison Service (SPS) to NHS Scotland in November 2011. Therefore, NHS Scotland Boards are now responsible for the provision of healthcare services for people in prison within their geographical boundary. There are nine Boards that have prisons within their boundaries, and five that do not. A Memorandum of Understanding (MoU) between the SPS and Health Boards with prisons in their area details respective responsibilities and governance. The commissioning of social care in prisons remains the responsibility of the SPS.

A review of the transfer of health care services by the Royal College of Nursing Scotland in 2016 presented a mixed picture of progress towards delivering better outcomes for people in prison, and substantial room for improvement to reduce health inequalities and meet the health care needs of those in prison.[2] Although the review indicated improvements in access to services and continuity of care in some cases, it also highlighted significant challenges to healthcare provision in prisons. These included pressure on staff and resources, low morale of the nursing workforce, and a lack of national reporting and quality outcomes data to shape service planning. More recently, some local health needs assessments have been carried out, or are being considered, with examples of in-house data collection generating actionable, prison-level recommendations.[3]

Fifteen years on from the last national assessment, an up-to-date review of health and care requirements in Scotland's prisons was a recognised priority to ensure the most appropriate services are in place for individuals in prisons across the country. Therefore, in 2020/21, the Scottish Government commissioned research to provide a comprehensive, national assessment of needs in the prison population in relation to four domains of health: physical health, mental health, social care and substance use. These studies were carried out by:

[1] Graham, D.L., 2007. Prison Health in Scotland-A Health Care Needs Assessment.
[2] Royal College of Nursing Scotland, 2016. Review of the Transfer of Prison Health Care from the Scottish Prison Service to NHS Scotland.
[3] NHS Highland, 2021. Health and Healthcare Needs Assessment: Inverness Prison.

- The University of Leicester;
- The University of Edinburgh and the Forensic Network;
- Alma Economics; and
- Figure 8 Consultancy Services Ltd.

Each research project took a broadly similar approach, estimating the prevalence of certain needs, which is consistent with standardised approaches to conducting prison health needs assessments. The substance use project, however, relied less on quantitative modelling and took a more qualitative approach. Across the projects, the Covid-19 pandemic hindered face-to-face data collection with people in prison. Reviews of literature, mapping methods, and remote interviews with stakeholders and people with lived experience were used to overcome these methodological challenges.

This report draws out common themes from the four projects. Taken together they provide a rounded picture of health and social care needs, service provision, and key issues and challenges to meeting health and social care needs in Scotland's prison population. The evidence synthesis was conducted by analysts in the Scottish Government Health and Social Care Analysis Division in three stages:

1) A thematic analysis of recommendations (from the project reports where these are explicitly provided) to identify key themes.
2) A review of each report to test and refine identified themes iteratively.
3) A presentation to the Prison Population Needs Assessment Advisory Group to discuss the proposed themes, with a subsequent revision.[4]

The recommendations presented in this synthesis report are taken from the three reports where they are made explicit (the social care report does not include recommendations). Recommendations here are not exhaustive of each individual report, but provide a summary of strategic and operational recommendations that appear in more than one report and cut across health domains. The purpose of this report is to draw out those common themes; however, it may be that the most important recommendation(s) for one aspect of health is not relevant to another. Therefore, it is important that the recommendations within individual health needs assessment reports are acknowledged and considered as part of any work to implement change in their respective areas.

[4] Organisations represented in the Needs Assessment Advisory group include the National Prison Care Network, Public Health Scotland, the Scottish Prison Service, Her Majesty's Inspectorate of Prisons for Scotland, Community Justice Scotland, NHS Lanarkshire, Community Justice Sector Voluntary Forum and Scottish Government.

Key themes

1. Consistency

Around choice and quality of provision

All four research reports describe a high level of health and care needs among Scotland's prison population. The reports note a high level of comorbidity (having more than one mental health, physical, social care or substance use related need) in Scotland's prison population. There is agreement that the scale and range of support services available do not consistently meet these needs. For example, reports identify unmet need relating to age, mental health issues, substance use and hidden disability.

The reports highlight examples of effective multi-disciplinary mental health services and community integration services. For instance, there is enhanced input from clinical psychologists and allied health professions providing mental health support to people in prison since the last needs assessment, and effective examples of third sector and community services in some local authorities providing support to people being released from prison. Yet the variation in in-house and community provision means that people in prisons or returning to the community do not experience the same choice and quality of health care and support across the country. At a prison-level, one report indicates that staffing and resources do not consistently relate to a prison's size and demography.

Around ways of working

From a stakeholder perspective, multi-agency working within prisons remains a challenge to ensuring consistent, quality health care for residents. Stakeholders point to differences in culture, working practices and information systems between the SPS, NHS and partner agencies as issues that contribute to silo working. There are examples of good NHS-SPS relationships at a strategic and operational level but a view that more could be done to strengthen strategic partnerships and cooperatively provide support to people in prison. Two reports recommend a formal, national partnership between organisations that is empowered to deal with strategic and operational issues across prison and health services, and supports the implementation of improved practice.

Around prevention

There is consensus across the reports that health and care interventions in prisons tend to be reactive rather than proactive, with resources targeted mainly at acute conditions. It is acknowledged that a large population could benefit from more holistic and person-centred support that acknowledges underlying trauma and the underlying causes of an issue. In particular, wider support that focuses on up-stream determinants of health (for example, education, social relationships and help with housing) and helps residents prepare for the transition back into the

community. One way of shifting the focus to prevention and driving consistency highlighted by reports is to develop a single, person-centred model of care.

Recommendations

- The resources allocated to health and social care in prisons should reflect the multiple, complex needs of individuals in prison, the benefit of preventative services, and the specific size and characteristics of a prison.
- A formal partnership should be developed between key partners involved in the commissioning and delivery of health care and support to people in prison.[5] The partnership could clarify responsibilities, enable joint decision making, and offer opportunities for governance and quality improvement.
- SPS and prison based health care should work to develop and adopt a shared model of care. This model of care should be person-centred and proactive, i.e. it recognises the life experiences of the individual and the social, physical, economic and environmental influences on health.

2. Information sharing

At a population level

All four reports outline similar challenges in producing robust prevalence estimates, as health data relating to Scotland's prison population are registered on different systems, with different levels of reliability and timeliness. There is no central collection point of health needs and outcomes for Scotland's prison population. Better information sharing at this level would allow SPS and NHS to more effective monitor needs, identify and respond to trends and inequalities, and plan and resource appropriately.

The research reports draw on publicly available national survey data and modelling to create estimates, which have likely generated underestimates of need. The most reliable data are from a bespoke data linkage project, which links prison records with Public Health Scotland data at an individual level, to give aggregate, anonymous prevalence estimates of health needs. This allows comparisons of health and social care needs between prison populations and populations with similar demographics outwith prisons.

At an individual level

According to stakeholders there is limited information sharing between justice, health, social work and the third sector. Information sharing is thought to be good between prison based and hospital/community-based health care teams for arranging secondary care appointments, but difficult and time consuming at the

[5] Needs assessments suggest this partnership could include (but not be limited to): SPS and private contractors (currently Serco and Sodexo), the National Prison Care Network, all Scottish Health Boards, the Criminal Justice Third Sector Forum (CJVSF), all Integration Authorities, and all Alcohol and Drug Partnerships.

point of transitions for an individual moving between prisons, or between prison and the community. Prisons that receive individuals from a number of health boards can face challenges or delays accessing prior health records from other boards and other clinical information systems.

Difficulties transferring health records between prison based health care teams and community based GPs can mean the rationale behind prescriptions are lost. Where health records do follow an individual, lived experience suggests that prescribing practices vary between establishments and health boards, which can result in unexpected adjustments to medications for individuals in prison. Two reports recommend a common prescribing formulae to reduce inconsistencies in prescribing practices within the prison estate, and when people move back into the community. One report emphasises the richness of information that families of people in prison have on a person's needs, support and coping strategies, and advocates for a mechanism to be able to share this information.

Recommendations

- Create a system of joined up data sources on the mental and physical health of individuals in prisons, for example through data linkage, to provide reliable prevalence data so that these can be monitored at a national level, and compared with other population groups.
- Ensure information sharing protocols between key professions involved in the care and support of a person in prison are effective, so that professionals can access relevant information efficiently.

3. Access to services

Identifying need

The research reports call to attention the complexity of concurrent health conditions in Scotland's prison population. Mental health and substance use can have direct and indirect associations with one another, and interact with physical health and social care needs. It is reported that, although prisons present a unique opportunity to address health needs, prison environments can heighten the impact of certain illnesses.

Initial screening for health issues on entry to prison are shown in the reports to be useful in generating referrals to primary health care services. However, people with lived experience indicate that reception is a time of extreme stress, with a number of reasons why they might not wish to disclose health care concerns or substance use at this point in time, including due the risk of stigma. Two reports agree that subsequent health care screening in the days following reception could pick up on needs that are not obviously recognisable or immediately prioritised, such as Autism Spectrum Disorder or needs related to substance use. The days following reception may be a more appropriate time to complete a thorough assessment of need, which would enable a more complete management plan to be formulated.

Logistics

Funding and issues of security are highlighted as barriers to people in prison accessing specialist care. In particular, missed appointments due to difficulties sourcing suitable transport are raised as a challenge. However, reports indicate positive developments in video consulting services (for example, Near Me), which are largely due to adaptations to health care delivery during the Covid-19 pandemic. While video consulting is not fully evaluated in the assessments, they note it has widened access to services by reducing the logistics of moving people between prisons and hospitals. Going further, two reports emphasise the need for SPS and health care providers to identify a solution that maximises time available each day for health staff to see their patients.

Appropriate services

The data presented in research reports show that some groups in prisons face disproportionately higher levels of health needs. For example, for mental health, the prevalence of conditions is generally higher in younger age groups, and in females relative to males (except for alcohol use and depression). For physical health, white residents, females and individuals aged over 50 are typically more likely to have worse health. Across both physical and mental health, people on remand and those in older age groups are evidenced to have particular needs and to experience gaps in services and support. It is argued that information about the needs of particular groups could be better used to guide interventions and improve engagement.

Recommendations

- A second assessment for physical health, mental health and substance use issues should be held in the days following reception, to more fully capture an individual's needs, identify appropriate interventions and support individuals to make an informed choice about their treatment.
- A review of current transport arrangements to secondary care appointments and expansion of video calling technology to ensure that specialty services are accessible to those in prison.

4. Staff

A range of staff interact with and provide support to individuals in prisons. These include NHS health care staff (mostly nurses but also GPs, pharmacists, psychologists, administrators and consultants) and SPS staff (prison officers and staff from contracted organisations). Other support services are delivered by professionals visiting or off-site, which includes social workers, third sector staff, dentists, opticians, other consultants and allied health professionals.

Shortages

Across all four research reports, adequate staffing is acknowledged to play an important role in the uptake of health and social care interventions in prisons. There are positive developments in staffing mentioned, for example, enhanced multi-disciplinary prison mental health services. There are also examples of insufficient staffing, for example, reduced capacity in transport services contracted by SPS, leading to missed health care clinics or dental appointments.

The reports collectively highlight that Covid-19 exacerbated existing, significant problems with prison based health care staff shortages and low retention rates, in particular nursing staff. Covid-19 sickness absences, self-isolation requirements and the reallocation of staff from normal duties resulted in staff shortages. Separate from Covid-19, stakeholders voice that generally high staff turn-over in prisons can be related to feelings of being under-resourced and over-worked (in relation to NHS staff) and a lack of recognition of the value of the work they do (in relation to third sector staff).

Two reports consider a career pathway for prison based health care staff as a way to promote retention. It is thought this could offer greater opportunities to develop skills and obtain experience of working with patients in a range of different settings in justice and the community, and support career advancement. Helping the workforce stay informed about their own health and wellbeing, and get support where needed, is also highlighted as a way of addressing issues of staff shortage and retention.

Education and training

While the availability of training is generally acknowledged to be good, stakeholders voice that staff capacity can influence opportunities to participate. In addition, they say that training opportunities vary by profession, which may hinder a whole prison approach to promoting good health and keeping people safe. The reports identify areas where mandatory training would be beneficial, for example, training for all new staff based in prisons (SPS, NHS and third sector) on health inequalities in the prison population, mental health and trauma, and the range of services available to people in prison, and pathways to access these. It is argued this type of induction training would reduce stigma, and help prison based staff proactively recognise concerns and respond appropriately.

Recommendations

- Action to address staff shortage and retention issues in prisons, for example, greater organisational recognition, emotional support and opportunities for development and career advancement.
- Mandatory induction materials for all prison based staff (SPS, NHS and third sector) on physical and mental health literacy and the remit of service providers, to reduce stigma, and improve knowledge of services available and pathways to access these.

5. Facilities

The reports raise the issue of facilities. In some (but not all) prison establishments, health care teams note that there is limited physical space for staff to undertake clinical work. Space was further restricted by distancing requirements during the Covid-19 pandemic.

Although there are reports of accessible cells and adaptations in development, stakeholders voice that older prison buildings and facilities are generally designed for younger, more able-bodied people. It is widely felt that adaptations are expensive and that population ageing will increase demand for dedicated care facilities in prisons for individuals with reduced mobility, physical disability, or palliative care needs.

According to those with lived experience, having access to daylight and alternatives to the gym for exercise purposes are important facilitators for good health in prisons. The need for suitable accommodation on liberation is also highlighted by those with lived experience and stakeholders as critical to help break the imprisonment cycle.

Recommendations

- Investment in prison facilities to provide adequate space for clinical assessments and interventions.
- A review of facilities to ensure they are accessible and adaptable for: disabled people, people with reduced mobility, people needing end of life care; and to ensure they can meet future population ageing demands.
- Improve access to support for housing prior to liberation to avoid habitual patterns of substance use and promote mental health.

Glossary of terms

GP	General Practitioner
NHS	National Health Service
PHS	Public Health Scotland
SPS	Scottish Prison Service

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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