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HEALTH SERVICES IN THE CRIMINAL JUSTICE SYSTEM

modern governance, new approaches, and the way forward in Europe

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HOW SHOULD WE organise health care to best meet the needs of those in contact with the criminal justice system? A recent publication from WHO comes down firmly in support of reforms whereby health care for those in contact with criminal justice passes to the control of the Ministry of Health, as has already occurred in the UK. This paper explores the rationale for this new thinking, and also asks what the main resulting benefits have been so far in England and Scotland.

Models of health care in justice

There are three main models for the organisation and provision of prison health services internationally:

1. By far the most common is direct provision of healthcare as part of prison services, and therefore the responsibility of the government ministry responsible for justice.
2. A mixed model, with primary health care directly supplied by the prison service and secondary care provided by local community hospitals. In this case the Ministry of Justice (or equivalent) remains 'in charge' of health within the prison. This was the service configuration in Scotland until November 2011.
3. Healthcare is provided by health authorities from the wider community, as provided for other citizens. The Ministry responsible for national or public health services, normally the Ministry of Health (MoH), commissions health services, and may also directly provide all or some of them. This model is relatively new, but has now been adopted by several European states and entities: Norway, France, two Swiss Cantons, two autonomous regions of Spain, Italy, Kosovo, and the UK, including Scotland since 2011. Several other States of the WHO/European Region have started or are considering a similar prison health reform, but elsewhere this model is still rare.

The European Region of the WHO's Health in Prisons Programme (HIPP), has recently issued a policy brief supporting the MoH led model (UNODC, WHO, 2013).

WHO's advice draws upon relevant studies on prison health as well as on international law relating to the legal and ethical requirements of prison health. It leads to the following main findings based on the premiss that prison health is public health.

- Prisoners share the same right to health as any other person.
- Prisoners come predominantly from vulnerable groups, and carry a higher burden of diseases than the general population.
- Prisons are settings with high risks of disease presenting a complex challenge for public health, especially with regard to communicable diseases.
- States have a special duty of care for prisoners including their health and healthcare.
- Prison health services should be at least of equivalent professional, ethical and technical standards to those applying to community public health services.
- Prison health services should be provided exclusively to care and must never be involved in the punishment of prisoners.
- Prison health services should be fully independent of prison administrations and yet liaise effectively with them at all levels to meet patients' health needs.
- Prison health services should be integrated into national health policies and systems.

WHO recommended that the management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners, is a whole-of-government responsibility and that health ministries should provide and be accountable for health care services in prisons. Predicted long term benefits include lower health risks and improved health protection in prisons, improved prisoner health, improved public health and better re-integration of prisoners on release.

Perhaps surprisingly, there have not been any comprehensive national evaluations of this type of reform in Europe or elsewhere. There have been collations of informed opinion and indications that such reforms are, on human rights grounds, the 'right thing to do', and on public health grounds, the 'beneficial thing to do'. For example, a 2004 conference report, evaluating reforms in Norway, France, England and Australia, found that in general "the gains can be great … the standard of care provided to prisoners has improved in all four countries. National health policy has greater awareness of the specific health needs of prisoners. Recruitment and policy of staffing has improved. Links with health services in the community have been strengthened" (ICPS, DoH 2004). Nonetheless, limited evidence to support these statements has accumulated in the interim.

There is evidence of common deficiencies and poor practices in health provision across Europe. Scotland has sought to comply with international standards and conventions, to uphold rights and meet responsibilities for health and healthcare for people in detention. One compelling reason to institute change in 2011 was the need to comply with international standards as well as criticism from the Prisons Inspectorate (Prison Healthcare Advisory Board, 2007).

Reform in the UK

People in prison in England and Scotland are now NHS patients, and NHS standards prevail, offering broadly equivalent services to those in the community. This has reduced the risk of previous problems occurring among health staff of 'dual loyalty' and professional conflicts of interest between patients and prison service management.

There has been significant additional investment in English custodial health provision since or as a result of the reforms (Hayton and Boyington, 2006) while stable levels of resource in Scotland reflect higher existing levels of investment at the time of reform. There are now systematic approaches to :

- health needs assessment;
- commissioning services; NHS England now commissions services for all prescribed places of detention and that includes, for example, people in police cells, Immigration Removal Centres, or in contact with probation services. Scotland has instituted a full set of changes for detainees, completed in 2014;
- standards; developed, monitored and implemented in line with the NHS quality and outcomes frameworks (Scottish Government, 2010);
- improving health informatics compatible with community-based systems;
- improvements in clinical drug treatment services for people in prison placing the prison system nearer the centre of initiatives to help those with substance misuse problems;
- and, complaints about health care are now handled within the remit of the health services ombudsman.

In addition, in England, the Prison Service and Ministry of Justice continue to be involved in a dynamic partnership approach in which health is seen as a key element within moves to rehabilitate and reintegrate prisoners.

Such changes have been widely welcomed in principle, local accountability for services to support those in contact with the criminal justice system has developed well, and there have been anecdotal reports of benefits to patient care for people with complex problems. Reforms have straddled sustained reductions in prison suicides, improvements in Hepatitis B vaccination uptake and spread of the disease, and enrolment and outcomes from smoking cessation programmes.

However, in Scotland systematic data collection and supporting systems of analysis to meet expectations of governance are not routinely in place. Key performance issues range across the effectiveness of throughcare, to support for those in transitions, especially those newly released from prison; improvement and risk management of services. Aside from healthcare, new governance demands a sustained focus on health for prisoners as one group with complex needs in the NHS, as well as recognition that prison is a setting that presents opportunities for health protection and improvement. For instance, isolation from family, the quality of food provision, security and availability of illicit drugs, smoking restrictions and a culture of respect between prisoners and staff are all important influences on health, and require a public health approach jointly between criminal justice services and the NHS.

In conclusion, whilst across the UK there is growing consensus that the NHS model is fit for purpose, in terms of human rights and healthcare standards compliance and improved health for all those in contact with the criminal justice system, evidence for assurance and governance is still under development. Progress in Europe towards better governance is likely to be a fairly slow process. More thorough evaluation of progress in those countries that have carried out reform is important to sustain modern governance, demonstrate delivery of each State's duty of care to detainees, and to allow other countries to benefit from experience when they opt to do so.

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