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scottish justice matters

HEALTH AND (IN)JUSTICE

Edited by Andrew Fraser and Maggie Mellon

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HEALTH AND JUSTICE

common problems, solutions and purpose

Lesley Graham and Andrew Fraser

PEOPLE who come to the attention of the criminal justice system in Scotland are drawn predominantly from communities that experience poor physical and mental health, often associated with a lifetime of social exclusion, lack of employment, hope, purpose and their consequences. Challenging, promoting and protecting the health and wellbeing of offenders, and those at risk of offending, can have benefits for individuals, their families and communities as well as wider society. The delivery of healthcare in criminal justice settings offers an opportunity to reach some of those who are hardest to reach in the community and so tackle health inequalities, which remain a major problem in Scotland, and has the potential to reduce crime and re-offending.

As well as having one of the most unequal societies in Western Europe, Scotland has one of the highest imprisonment rates. Overcrowding and constant movement of prisoners, many who are in prison for a very short time, remain issues. This creates huge challenges for detection and assessment of health problems and needs, and delivery of integrated care, both within prison and in the transition between prison and the community. Healthcare also has to be delivered in a setting where custody and good order must be effective at all times.

That applies equally to police custody, where throughput is also high (approximately 200,000 episodes per annum) with detainees often in custody for 24 hours or less (HFSPPCN, 2012). The limited evidence on the healthcare needs of police custody detainees (UK) shows a high prevalence of morbidity, particularly of mental health and addiction problems with many in an acutely distressed or disorientated state.

> Imprisonment confers a sharply increased risk of death over and above the poor health record of communities from which most prisoners are drawn

The health profile of prisoners in Scotland paints an equally bleak picture. The starkest aspect of a prisoner's profile on reception into prison is the likelihood of having a problem with or dependency on alcohol, drugs and tobacco. Nearly three quarters (73%) of prisoners have an alcohol problem, with almost two in five (36%) of those likely to be alcohol dependent. Nearly half (45%) reported being under the influence of alcohol at the time of their offence. 77% of prisoners tested positive for illegal drugs on reception to prison (33% for opiates) and 39% of prisoners reported being under the influence of drugs at the time of their offence. 74% of prisoners smoke compared with 26% of men and 23% of women in the general population. Nearly one in five of those in prison (19%) are estimated to be Hepatitis C positive.

There are no robust figures for the prevalence of mental health problems in Scottish prisoners though prescribing indicators suggest a considerable burden, in particular for depression and psychosis. 14% of prisoners were reported as having a psychiatric history and 7% a history of self-harm, including attempted suicide. 4.5% prisoners were identified as having a 'severe or enduring' mental health problem, rates of which were higher than those in the general population.

Severe dental decay in male prisoners was three times that of the general population (29% compared to 10%) whilst for women prisoners it was 14 times greater (42% compared with 3%). Prevalence of certain long-term conditions was found to be higher than in the general population (such as asthma and epilepsy), whereas others were similar or lower (such as diabetes and coronary heart disease), possibly due to the young age profile but also fewer opportunities before coming to prison to approach services for detection of health problems (Graham, L 2007).

Imprisonment confers a sharply increased risk of death over and above the poor health record of communities from which most prisoners are drawn. A Scottish study on the mortality of those who had been imprisoned in Scotland found that men were over three times more likely to die (3.3) than the general population and women over seven (7.6) times more likely to die, with risks elevated even after accounting for deprivation (2.3 and 5.7 respectively). Relative risks were highest for drug and alcohol related causes, suicide and homicide, and were markedly higher in women than men. The majority of deaths occurred outside prison, with deaths most frequent in the first two weeks after release. Mortality rates were lower in those with longer total duration in prison but higher in those with multiple, short episodes of stay (Graham, L. et al 2010).

The high risk of dying soon after leaving prison calls for joint action both to divert people from crime and imprisonment, especially for short periods, and effective, co-ordinated support from the moment of leaving the prison gate. Health policy has increasingly recognised the health needs of those in criminal justice settings and that addressing their health needs can also help tackle health inequalities. In 2007, the Better Health, Better Care Action Plan stated 'it … makes sense for NHS Scotland to review its approach to the health and health care of offenders and ex-offenders and to consider what more can be done in prisons and custody settings to ensure continuity of care during the transition between prison and the community' (Scottish Government 2007). In November 2011, responsibility for delivery of healthcare in Scottish prisons moved from the Scottish Prison Service to the NHS (see Hayton et al, page 9). Better transitions and throughcare were key objectives of the change, underpinned by the guiding principle that health care in prisons should be equivalent to that delivered in the community.

Scotland's prison healthcare is nurse led, enhanced primary care, with additional services for mental health, addictions and Blood Borne Viruses (BBVs). Nine Health Boards have prisons located in their area although all share responsibility for the healthcare for ex-prisoners on release. The SPS and other agencies also have a role and responsibility in promoting wider health improvement of those in prison, as set out in the framework Better Health, Better Lives (ScotPHN, 2012). It is crucial to ensure continuity of care on release, not only for sustaining the health gains achieved in prison and saving lives immediately thereafter, but also to promote reintegration and prevent re-offending.

The NHS also now delivers all healthcare and forensic services for people in police custody, with Police Scotland retaining statutory responsibility for forensic healthcare services.

In further recognition of the importance of offender health, a new NHS post of Director of Health and Justice has been created, to provide strategic leadership and promote cross sector working.

Recent justice policy in Scotland has highlighted that addressing the health needs of offenders is important in order to reduce re-offending. Prisons have been and are being modernised to be fit for purpose: more prisons are to be 'community facing', allowing prisoners to be nearer to families and friends; crucially and reflecting the severe and multiple problems that imprisoned women face, the management of women prisoners is being reformed following the influential Angiolini Commission on Women Offenders (2012).

The SPS review, Unlocking Potential, Transforming Lives, adopts a person-centred, asset based, desistance approach with an emphasis on collaborative working with community partners (SPS 2014). Other reforms that could impact on health and justice include the introduction of Community Payback Orders; a presumption against short-term sentences of less than three months; the redesign of community justice structures, with Community Planning Partnerships taking on responsibility for the local planning and delivery of services to reducing re-offending. Innovations include the 'whole systems' approach with young offenders as well as mentoring schemes for prisoners on release.

Offenders are often the most vulnerable, unwell and disadvantaged individuals in our society. The factors underlying offending and poor health for example, early traumatic years and poverty, are often the same. Both desistance and recovery have common solutions, such as addressing wider health and wellbeing and social inclusion (see McNeill and McCartney p. 7). Achieving that requires working in partnership, not just in the health and justice field with important voluntary and social enterprise organisations, but across the whole public sector. 'Upstream', fundamental and preventive interventions such as those that sustain more resource and greater hope amongst those who have least, and face the greatest challenges, need to be rebalanced with 'downstream' care and support with meaningful outcomes. The challenge ahead is to tackle inequalities that drive and determine future risks of offending and poor health, and to keep focused on that common purpose.

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Lesley Graham, associate specialist, public health lead for drugs, alcohol and offender health, ISD, NHS National Services Scotland.

Andrew Fraser, director of public health science, NHS Health Scotland