Volume 2 | Number 2 | June 2014

scottish justice matters

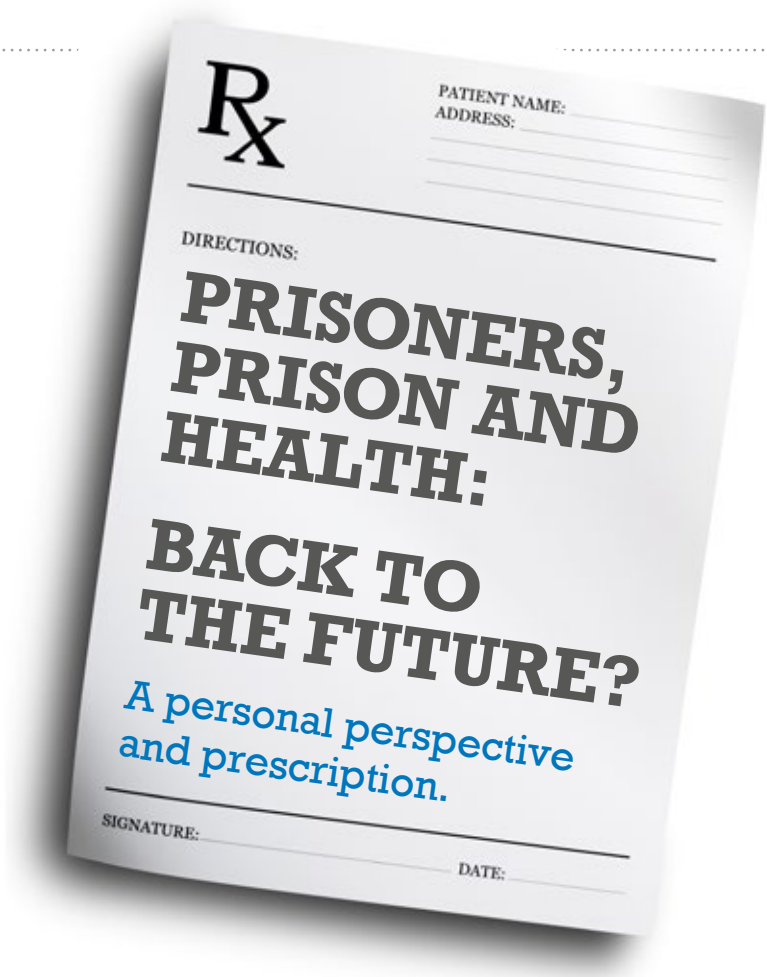
HEALTH AND (IN)JUSTICE

Edited by Andrew Fraser and Maggie Mellon

Featuring: Health Inequalities • Older Prisoners
Mental Health • Drug Misuse • Neuroscience

ALSO: Current Issues • History • International

ISSN 2052-7950
9 772052 795005



Dan Gunn

I HAVE just retired after nearly four decades working in Scottish prisons, finally as Director of Operations. Undoubtedly one overwhelming change in my time 'inside' is the recently enhanced importance of health care. In some prisons it dominates the entire regime and in others is central both in terms of policy development and meeting individual need. But just how well understood is this major change within and without the SPS?

When I joined as an Assistant Governor in Perth, health was a small, self-contained part of the prison. The prison nurses were in prison staff uniform. The Medical Officer was not known for his bedside manner and it was a brave, if not foolhardy Hall Governor, who advocated on behalf of a prisoner. In six years, I remember only one Governor grade reflecting on health care, and that only when he was about to be transferred!

Prisoners were mostly young men: 25 plus was seen to be old, and 36 plus bordering on ancient. Forty years on we have an ageing prisoner population (average in the mid-30s), a good number between 40 and 70 and, incredibly, some in their 80s. Some jurisdictions have an upper age limit on imprisonment. Scotland does not. This raises the issue of which of the generally accepted purposes of imprisonment applies to incarcerating old people suffering from dementia? 2012 saw the imprisonment of an 81 year old lady on remand for making nuisance phone calls to the police and in 2009 the Parole Board found itself unable to release a recalled lifer with no limbs and a short life expectancy. Presumably he was still a risk to the public? In 2013-2014 SPS had a record number of deaths in custody from natural causes and one establishment currently has nine terminally ill prisoners. Are the complexities and importance of health in prisons today fully appreciated?

Historically, the first relevant legislation, the Health of Prisons Act 1774, provided that every jail should have an experienced surgeon or apothecary: by 1840 every prisoner was to be visited weekly by the surgeon. The power of the Medical Officer was notable and a triumvirate consisting of the Governor, the Chaplain and the Medical Officer ran 19th century prisons.

The Elgin Report (1900) examined "The provision made in Scottish prisons for the nursing and accommodation of sick prisoners" and argued that "A sick prisoner ought, we think, to receive at least as prompt and satisfactory treatment as he could have obtained had he not been in prison". This principle, known as equivalence, continues to be at the heart of government policy. For many years I opened the Induction programme for Practitioner Nurses with this quote which most thought was very recent. Sadly reports into prisons during the 20th century did not focus on health and the professionalisation of the Nursing Service and the emergence of a nurse-led health service was the only fundamental change. It arguably led to the SPS becoming a leader in health care, although the nursing staff in Scottish prisons became frustrated that their expertise was not sufficiently recognised by colleagues in the NHS.

From the late 80s a combination of AIDS, drugs (legal and illegal), self harming, mental health and acceptance of alcohol abuse were evident. During my time as Governor of YOI Polmont (1996 to 2004) we prioritised health care within a changing ethos. A discrete mental health team wore a different uniform and were intended to be visible and accessible, a change seen to benefit good order, personal safety and a sense of wellbeing. Smoking cessation was prioritised. The wider objective was to show change was possible. If a young person could change his behaviour in one addictive area then arguably he could do it in another.

The seminal Social Exclusion Unit Report on Reducing Re-offending (2002) stressed the importance of prisoners' mental and physical health problems, and recognised that "the Prison Service and NHS have made real progress" but also noted that "good practice is still scarce", identifying issues of adequate assessment and post-release arrangements. The overriding principle remained equivalence. It might however have asked whether provision was sufficient? It also recognised a wider agenda, arguing that "untreated mental and physical health problems could be made worse by imprisonment" thus exacerbating challenges of finding or keeping a home or a job. It pointed out that time in prison can present a valuable opportunity to address some of these issues and called for further work to ensure post release help. Lesley Graham's report, Prison Health in Scotland: A Healthcare Needs Assessment (2007), specified no less than 13 domains where work was underway, often multi-professional.

Prison health care will always rightly be primarily a response to presenting need but these wider considerations are vital to rehabilitation. Back in 1912 it was argued that "the treatment of a criminal is a matter of public health" (Devon, 1912). Is this recognised today and what implications are there for policy, resource allocation, and the integration of services to support any prisoner on release?

Health promotion opportunities in prison are one aspect of this public health dimension. The first SPS multi-disciplinary group to look at this, which I chaired, focused on smoking, diet and activity. Current Scottish work, implementing Better Health, Better Lives for Prisoners (2012), is arguably too wide-ranging and in reality health promotion or improvement remains merely 'nice to do'. SPS should provide clear and inspirational goals, not a resource issue but about commitment at practitioner and senior management level. Health promotion activities can be fun and involve mass participation, not to be underestimated in a prison context. The potential remains huge.

A focus on public health also allows analysis of the widely recognised and debated link between health inequalities and offending. But have criminal justice or health practitioners and policy makers have devised action plans? The Management of Offenders Act (2006) specified the first of of nine offender outcomes as "The central belief that better health and wellbeing can contribute to a reduction in the rate of re-offending". But just how widespread was and is this "central belief"? Health features in the priorities outlined in the Strategy for Justice (Scottish Government, 2012), but are we any closer to establishing exactly what 'better health and wellbeing' can contribute to reducing re-offending? Statisticians have not focused on this area, and advocates of desistance have not focused on offender health or the ageing prisoner population. This is not so much unfinished business as business yet to start.

In summary, this article offers four main arguments. First, we should recall the precedent set in 1913 by the appointment of a Prison Medical Officer as a Prison Commissioner. Should the newly created Director of Health and Justice in the Health Department not be a Non-Executive Director on the SPS Board and a member of the Justice Board?

Second, the importance of health care has still to be truly recognised internally and externally. There should be an annual Health and Criminal Justice conference, run jointly by Justice and Health departments and third sector and advocacy organisations, such as SASO and Howard League Scotland, should be encouraged to include health as a matter of course in their programmes.

Third, there needs to be a greater awareness of aspects of prison life which affect health and wellbeing and require a multi-disciplinary approach, reflecting best practice outside, inside. These should include the protected characteristics of the 2010 Equalities Act, bereavement counselling, speech and learning therapy, management of terminal illness and social care.

Finally, we need a new paradigm for the governance of health in prisons and effective support on release, starting with new performance measures in respect for governors and local health managers. The Supporting Prisoners Advice Network is the only body focused on this agenda but has no less than 11 current priorities and 13 emerging issues and no executive or dedicated funding.

The SPS is adopting a new theoretical model placing the prisoner at the heart of all that should happen in a prison, with the objective of unlocking potential and transforming his/her life chances on release. The Strategy for Justice called for ambition and innovation. What is the joint justice and health input to be? Who will be prescribing what to whom and when? The eighteenth century penal reformer John Howard prioritised health: today is the time to go back to the future.

Better Health, Better Lives for Prisoners (2012) http://www.scotphn.net/projects/previous_projects/health_improvement_in_prisons/

Elgin Report (1900) *Report from the Departmental Committee on Scottish Prisons*. HMSO.

Graham, L (2007) *Prison Health in Scotland: A Healthcare Needs Assessment*. SPS.

Scottish Government (2012) *The Strategy for Justice in Scotland.*

Social Exclusion Unit (SEU) (2002) *Reducing re-offending by ex-prisoners*

Supporting Prisoners Advice Network http://www.sacro.org.uk/services/criminal-justice/supporting-prisoners-advice-network

Dan Gunn is a retired prison governor.

He wishes to thank all NHS and SPS colleagues who helped in the writing of this article but the opinions and recommendations are solely his responsibility.