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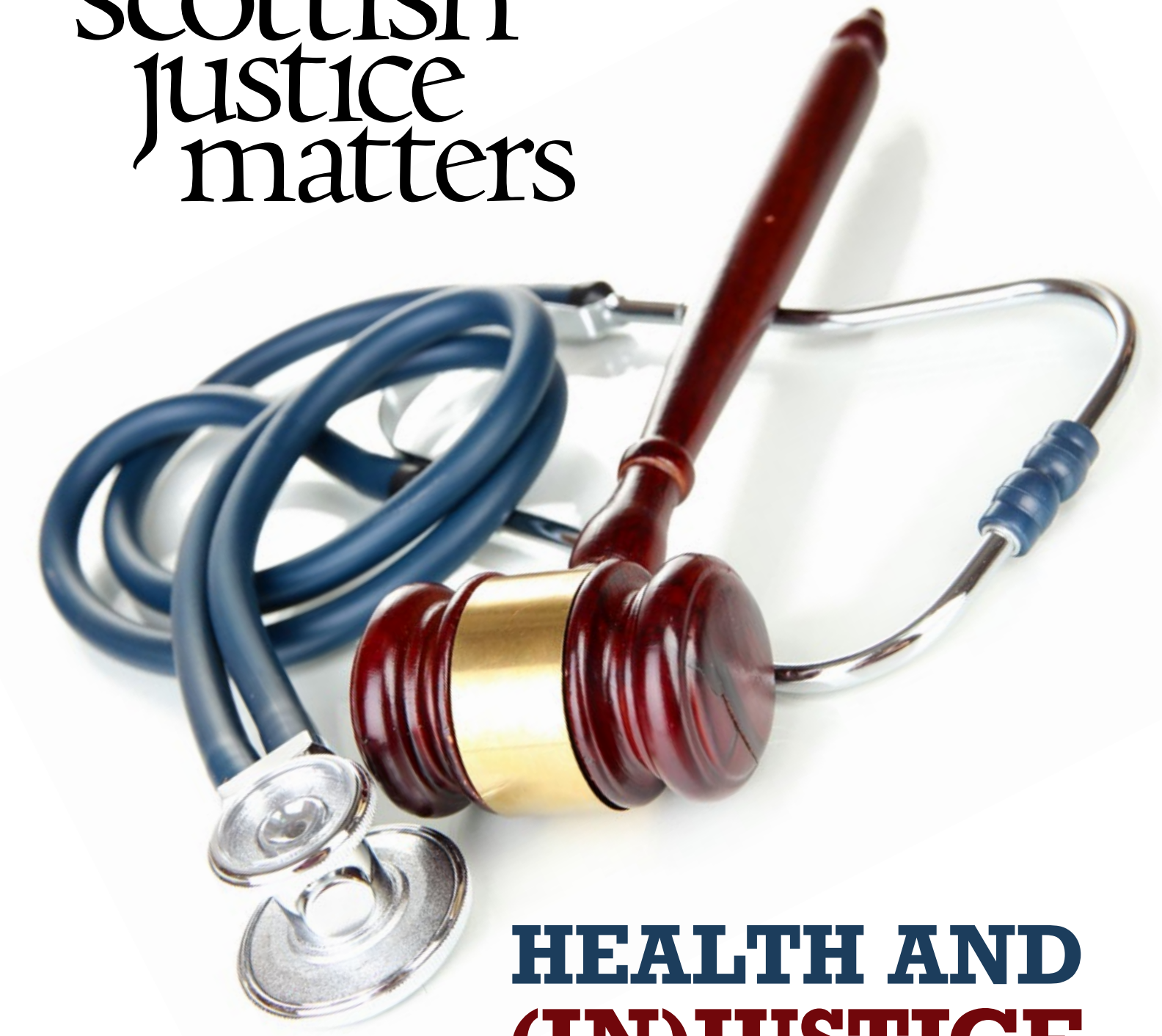
scottish justice matters



HEALTH AND (IN)JUSTICE

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Is the Scottish Prison Service looking after its older and frail prisoners?

Sarah Couper and Andrew Fraser

THE NUMBER OF PRISONERS AGED OVER 50 in Scotland increased by 71% from 387 in 2001 to 660 in 2011. Numbers are likely to rise further in future due to the trend for longer sentences, people surviving longer into old age and the older age of some sex offenders when detected and sentenced.

The definition of an 'older prisoner' is subject to debate, but age 50 upwards is most frequently used (Loeb, 2006). Prisoners are often in poorer health than the general population and so may become 'elderly' before their time (Aday, 1994).

The associated health and social care issues more prevalent in this group mean that the prison regime may be more challenging for them; they may rely on prison staff or other prisoners to assist them with daily activities. Despite improvements in the prison estate, physical facilities may also pose challenges, such as lack of space in cells for wheelchairs and special aids and appliances to support care. However, these problems do not solely affect older people. Many older prisoners remain in relatively good health and younger prisoners, due to poorer general health in the deprived population from where they are predominantly drawn, may also suffer illness or disability. Any assessment of need should, therefore, focus on ability rather than age.

The issue of accommodating older prisoners or prisoners with severe ill health or disability has been raised from time to time. An SPS policy document Intervention and Integration (SPS 2000) published in 2000 reviewed options; an informal consultation took place in 2005, and a needs assessment reported in 2012.

Older and frail prisoners are still accommodated in existing facilities and regimes, albeit with significant modernisation of the prison estate. Cells designated for people with disability are now a feature in newer prisons.

How many people are affected?

Prior to 1st November 2011, the Scottish Prison Service (SPS) had responsibility for providing primary medical services to prisoners in Scotland. Prisons relied on paper records which made routine national monitoring of prisoners' health, and the quality of health care in prisons, very difficult. We therefore undertook a needs assessment to find out how many prisoners find the regime difficult due to disability, to inform discussion concerning how Scottish prisons can best accommodate them (Couper, unpublished).

Health Centre Managers in each of Scotland's 15 prisons completed a questionnaire for each prisoner supported by 'stepped up care', who had care plans, or who had problems with routine 'Activities of Daily Living' (ADLs) in May and June 2012.

> the daily challenge of coping with disability and supporting those who struggle is a matter of growing importance

All 15 prisons responded, reporting 67 people with long-term health issues. 48 required assistance with at least one ADL: Glenochil (20), Barlinnie (14), Shotts (5), Edinburgh (3), Kilmarnock (3), Greenock (2), Addiewell (1). All but one were male. Eight prisons including the open estate had no prisoners matching the criteria. The 19 people who required no assistance with ADLs are still relevant to this audit as their conditions make it likely that they will require some assistance in the future.

The age group with the largest number of affected individuals was 50-59, although 43% were under 50. Glenochil had the highest number of prisoners requiring assistance with three or more ADLs.

ADLs most commonly requiring assistance were: climbing stairs; walking and fetching their meals. 27 people were reported to need help walking, being dependent or not being able to walk. 17 prisoners (six in Glenochil), and another 11 in five other prisons used wheelchairs. 19% of prisoners in this audit (13 of 63) were reported as not coping with the prison regime and arrangements were reported not to be optimum in 49% of cases (33) and not satisfactory in 22%.

18 cases, in the respondent's opinion, would benefit from a prison facility dedicated to meeting care needs (Glenochil 11, Barlinnie 3, and one each in Addiewell, Greenock, Kilmarnock and Shotts). 13 of these were reported as not coping with the prison regime.

In a 2005 qualitative study on growing old in prison in Scotland, there was a strong preference among older prisoners to maintain a mixed age range 'like normal communities' and a recognition that functional ability, not age, were key determinants of coping with the prison regime: 'you are as old as you feel'. Recommendations were that there should be more focus on function and the design and detail of the daily regime, including informal peer support and monitoring, for older and less physically able prisoners. Staff in mixed age and ability prisons commented on making individual adjustments, such as people who are less mobile or have chronic diseases occupying the bottom flat cells, with more flexible daily routines and frequent informal checks for those who stayed in their cells (Fraser, 2005).

Options for provision of care

Although a relatively small number of prisoners were frail and in need of daily support for living, some had needs that were complex and required frequent attention. So what are the options for provision of care for people with disabilities in prison who require assistance?

Options detailed in the SPS policy document 'Intervention and Integration' were:

1. Maintain the status quo (older prisoners are 'absorbed into existing regimes and wholly or partly excluded from aspects of those regimes in an ad hoc way').
2. Provide appropriate facilities across the adult prison estate.
3. Establish, as part of a larger prison, a facility for elderly people (at least for male prisoners) where specialist care services and prison staff expertise could be developed.
4. Develop resources and services in a small number of sites (SPS, 2000).

The number and distribution of prisoners who require significant assistance do not appear to support the need for a national facility. However, there are larger numbers in some prisons (Glenochil, Barlinnie and Shotts), and even a few prisoners with additional support needs for ADLs can place large demands on both the health and prison services. In addition, people with 'high needs' can arrive in prison from the courts with very little or no notice. If numbers rise and needs become more complex, a more efficient solution may be a secure facility adjacent to a care institution, rather than a care facility in a secure place such as a prison.

Glenochil had the highest number of people requiring assistance with ADLs, requiring assistance with 3 or more ADLs, using wheelchairs, not coping with the prison regime and for whom current arrangements were reported not to be optimum. If some prisons were to make special provision for 'stepped-up care', this would raise the option of transferring prisoners with high needs to those facilities. However, this might create social and sentence management problems if prisoners were moved farther from home to receive care. Whilst older prisoners expressed a preference for maintaining integration of varying ages of prisoners, the need for alterations in the prison regime for affected individuals has to be a priority.

The physical infrastructure of some prisons creates access problems for some prisoners. Stairs and walking are two of the most common problems. Therefore, changes to physical facilities, such as access to lifts, cells with space to manoeuvre, access to social areas and services are needed to counteract these.

Lines of responsibility for social care are presently unclear between health care and prison staff. Currently, social care assistance is provided from health care staff, prison staff and other prisoners. This varies according to the problem and the prison. Responsibility for pushing wheelchairs is a basic care requirement that needs to be assured. Options for the provision of social care include: peer support (i.e. training prisoners to care for other prisoners) or professional provision. Discussion should take place with prison staff and the local soon-to-be Health and Social Care Partnership as to who will provide social care.

'End of life' care was not reported as a current issue in any of the prisons in the 2012 survey. However, palliative care is an important issue. There have been examples of exemplary care for prisoners who remain in prison to die. This matter will become a more frequent problem in the future due to the ageing prison population.

Frail prisoners present a challenge for Scottish prisons. Numbers may be modest but the daily challenge of coping with disability and supporting those who struggle is a matter of growing importance for individuals and prison managers. Options now need to be debated by by responsible agencies in order for local arrangements to provide the optimum solution to caring for frail prisoners.

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