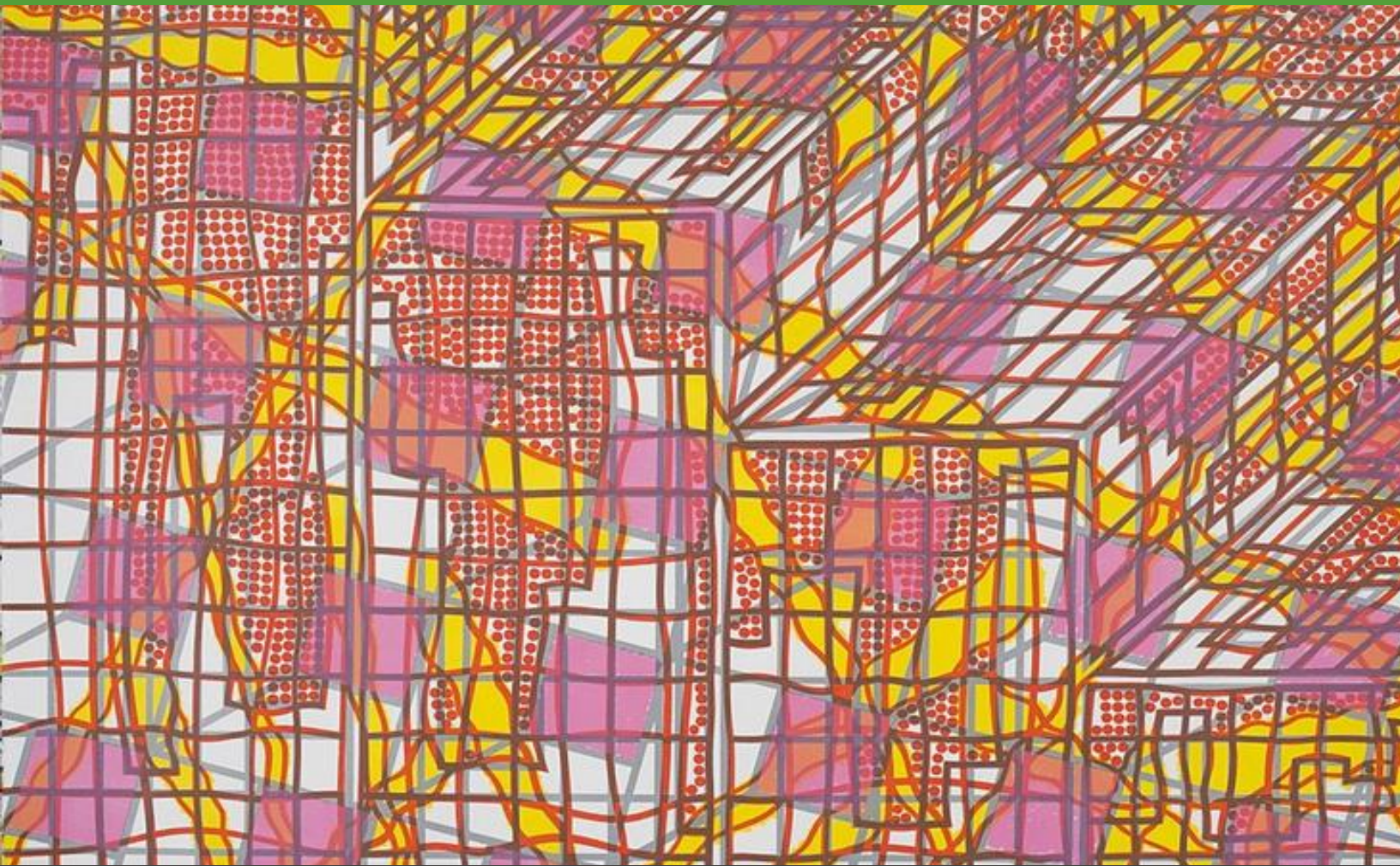


A New Vision for Social Care in Prisons



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Abbreviations

ADASS	Association of Directors of Social Care
ADL	Activities of Daily Living
CRPD	UN Convention of the Rights of Persons with Disabilities, 2006
DPO	Disabled Persons Organisation
ECtHR	European Court of Human Rights
ECHR	European Convention of Human Rights 1950
HASI	Hayes Allied Ability- Screening Index
HMIP	Her Majesty's Inspectorate of Prisons
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HRBA	Human Right Based Approach
IJB	Integration Joint Boards
IMB	Independent Monitoring Board
ICM	Integrated Case Management System
NCS	Norwegian Correctional Service
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
NMR	Nelson Mandela Rules
NOMS	National Offender Management Service
NPHN	National Prisoner Healthcare Network
NPM	National Preventative Mechanism
OHSCAP	Older Prisoner Health and Social Care Assessment & Plan
SDS	Self-Directed Support
SPS	Scottish Prison Service
SSSC	Scottish Social Services Council
TC	Therapeutic Community
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

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Executive Summary

Introduction

The absence of formalised and sustainable social care in Scottish prisons is impacting on the lives of people in prison and their transition back into the community. The commissioning of this report is indicative of the Scottish Government's ambitions and commitment to transform the practice and experience of social care in Scottish prisons. This is pioneering, long term work, with complex challenges and no easy solutions. This report evidences an acknowledgement for the need for change and a willingness to work differently to achieve change in the lives of people in prison, a place where "home" must be re-defined, but must ultimately remain a place that enables active involvement and a meaningful life.

Social care in prisons has been identified as a priority area by the Scottish Government leading to the establishment of the Health and Social Care in Prisons Programme Board. In April 2018, the researchers were commissioned by Social Work Scotland to report on the Integrated Health and Social Care Workstream, one of four workstreams reporting to the Health and Social Care in Prisons Programme Board: Outcomes and Performance Management; Governance; Integrated Health and Social Care and Clinical IT.

Providing formalised and sustainable social care in Scottish prisons will demonstrate a commitment by the Scottish Government to situate the integration of health and social care within both a community and prison environment. Achieving meaningful and impactful social care in an increasingly diverse prison population is complex. Current legal and policy mechanisms provide a foundation for future development; we recommend that strategic planning and modelling should focus on the process of service delivery and enhanced understanding of working with diversity and embedding culture change.

Study Aims

What are barriers and facilitators to formalised and sustainable social care in Scottish prisons?

- ❖ Current Context: How is social care currently conceived, experienced and practiced in Scottish prisons?
- ❖ Policy Context: What are the challenges/opportunities for using current social care policy in prisons?
- ❖ Future Context: What is the vision for the future of social care in prisons?

Methodology

The project comprised three stages:

Stage 1: Literature Review: a thematic literature review was undertaken and was used to inform the data collection.

Stage 2: Data Collection: qualitative data were collected from interviews in three Scottish prisons; and an online survey. The interviews took place with prisoners (n = 8) and prison governors (n = 3), and the online survey was circulated to all of the Integration Joint Boards (IJB) Chief Officers (n = 31) and the Director of Adult Social Care in the Highlands and Islands (n = 1) (total: n = 32). Response rate 11:32 (34%).

Stage 3: Thematic analysis was used to analysis the full data set.

The research team recognises that this is a small sample. However, the findings provide a timely and very relevant insight into the current provision of social care in Scottish prisons and establish a foundation for future development.

Policy Context

We discuss the legislative frameworks that shape current health and social care in Scotland, but also locate decision-making within human rights and the broader field of international jurisprudence and law. We highlight some of the key strategic policies and processes necessary for the activation of social care in Scottish prisons.

Recent health and social care policy developments do not extend to social care in prisons. The 2011 *SPS/National Health Service (NHS) Memorandum of Understanding* sets out the NHS and Scottish Prison Service (SPS) roles and responsibilities following the transfer of healthcare into prisons. A social care equivalent is lacking, an absence that is particularly visible in light of the legislative framework shaping health and social care integration in the community. The *Public Bodies (Joint Working) (Scotland) Act 2014* covers the integration of health and social care in the community, but not in prisons. A social work role in prisons is embedded in the *National Objectives for Social Work Services in the Criminal Justice System: Standards – Throughcare*, 2004. The Throughcare Standards detail social work responsibilities around the transition of prisoners into, within and out of prison. We conclude:

- ❖ **Legislation:** The key legislative findings suggest that, notwithstanding the recommendations in relation to the *Public Bodies (Joint Working) (Scotland) Act 2014* and the *Social Care (Self-directed Support) (Scotland) Act 2013*, existing international Conventions and domestic legislation, including the ECHR and the UNCRPD, in tandem

with the *Equality Act 2010* (UK) should provide an overarching framework for guiding the development of social care in prisons and the disability policy landscape more generally.

- ❖ *Social Care*: Social care should be viewed as an Equality Duty that first and foremost, enables disabled prisoners to be on a commensurable footing with other prisoners, and secondly as a mechanism for meeting quality of life and developmental goals of the disabled prisoner.
- ❖ *Standard setting*: Standard setting around social care must align with the *Nelson Mandela Rules* and be combined with an understanding of intersectionality so that the needs of variant population groups (protected characteristics) do not ‘disappear’ from service monitoring and evaluation.
- ❖ *Reasonable Adjustment*: Reasonable adjustment is a core tenet of working within an equalities framework and as such should be central to social care assessment processes and instruments.
- ❖ *Accessibility*: Accessibility is a multifaceted concept and is not restricted to functional modifications. Instead, accessibility relates to barrier free environments which facilitate a disabled person’s engagement in all purposeful activities. Both the *Equality Act 2010* and the UNCRPD assert an anticipatory rather than reactive approach to creating barrier-free facilities, services and programming. The ECtHR is clear that inaccessibility can amount to inhumane and degrading treatment.

Literature Review

A thematic literature review was undertaken to inform the data collection. A socio-cultural definition of disability represented in the 2006 UN *Convention on the Rights of Persons with Disability* (CRPD) (Campbell, 2009, Goodley, 2011, Waldschmidt, 2017), guides our study of the criminal justice system’s responses to disabled offenders. Standards setting is critical in securing equalities for prisoners with protected characteristics and necessitates that the UN *Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules) 2015 and the observations of the Parliamentary Assembly, Council of Europe, *Detainees with Disabilities in Europe* (2018) formed the backdrop for the benchmarking of our analysis of the literature. The review draws on the notion of *desistence*, of promoting prison as an opportunity for preparing people in prison, irrespective of protected characteristics, for their release from prison; with a focus on prisons reducing crime and not as warehouses of punishment (McNeil & Schinkel, 2016).

The review first identifies characteristics of imprisonment dynamics in Scotland. Secondly, it discusses the deprivation of liberty and its consequences on health and wellbeing. The third and final section, examines social care, its definition and meaning as well as the socio-cultural dimensions of prison life that impact on social care and assessment.

Findings

In our analysis of the data we draw out thematic patterns, but also discontinuities in viewpoints and experiences without necessarily harmonising what might seem as contradictory accounts. The Scottish prison system is diverse in its responses to social care and so are the lives and professional experiences of the participants. The findings from this study are presented in relation to procedural and socio-cultural dimensions. The procedural dimensions address the *practical aspects* of developing social care in prisons, and the socio-cultural dimensions consider the *lived experiences* of prisoners. The findings are informed by our literature review and data analysis, they support the development of empowering social care, and conceiving of prison as a prisoner's 'home'. The procedural and socio-cultural dimensions highlight some of the key strategic policies and processes necessary for the activation of social care in prisons.

Procedural Dimensions

- ❖ Policy, planning and programmes should be developed according to global best-enumerative practices delineated by the UNCRPD which formulates disability as evolving, shaped by interactions with the person in their environment. As such, this new orientation represents a shift from the more traditional biomedical and functional approach to delineating disability.
- ❖ The Findings strongly suggest that current approaches to the provision of Throughcare need to be revisited and reviewed. This report asserts that social work services are required to urgently consider how they can more effectively support prisoners with social care needs and work more collaboratively with other professionals to ensure the seamless provision of services to prisoners in the move from the community into prison and back into the community.
- ❖ Of concern, evidenced through our data, was the absence of social work within the prison environment. Where there was a reference to social work, such referencing tended to refer to a lack of engagement with prisoners. Our study recommends that social workers should play a lead role in co-ordinating and assessing social care in prisons and that multi-disciplinary teams should have a greater diversity of professionals involved beyond medical or nursing staff, to include occupational therapists, mental health and rehabilitation workers.

Socio-cultural Dimensions

- ❖ This study recommends that a holistic definition of social care be adopted in accordance with the approach outlined in the *Dilnott Commission Report* (2011). We also propose a new framework, the ‘*Six Principles of Empowering Social Care*’ as a conceptual modelling tool to guide future collaborative thinking and working.
- ❖ The data support our assertion that the remit of social care should facilitate pro-active purposeful activities for disabled prisoners and that interventions should be introduced that support the transition to and development of an affirming disabled identity.
- ❖ Attention should be given to identify ways of empowering the voice and agency of prisoners including a voice over issues impacting on them at an individual level and over areas of prison life, such as through group peer mentoring programmes run by disabled people or disabled ex-offenders.

Recommendations

The *Six Principles of Empowering Social Care* act as scaffolding to contextualise the report’s Recommendations. The Recommendations are proposed to assist key partners to think about ways they can take forward progress made on social care and inclusion in the community, and extend and integrate this knowledge to include prisoners. This knowledge exchange will ensure that any proposed social care modelling be linked to a human rights framework and a socio-cultural understanding of disability. In the process of completing this project, it became clear that the primary focus of work must be in relation to better understanding the concept of social care and disability along with working with integrated teams.

The report Recommendations cover key areas for development and action that have emerged from the literature review and data analysis. The recommendations are designed to support and guide the implementation of formalised and sustainable social care in Scottish prisons. The project generated seventeen recommendations grouped under five thematic headings:

- ❖ **Knowledge and Understanding**
 1. Defining Social Care
 2. Understanding disability
 3. Learning and training
- ❖ **Legal Frameworks**
 4. Framework for responsibility and resource
 5. Transition between community to prison to community
 6. Rights based approach
 7. Equality duties and reasonable adjustment

- ❖ **Delivering Social Care**
 - 8. Role of social work
 - 9. Integrated working
 - 10. Outcomes approach
 - 11. Holistic assessment
 - 12. Peer carers
- ❖ **Working with Diversity**
 - 13. Cultural change
 - 14. Data and diversity
- ❖ **Wellbeing and Quality of Life**
 - 15. Purposeful activity
 - 16. Wellbeing and offending
 - 17. Alternatives to prison

The Recommendations are introduced and referenced throughout the report. Summary tables at the end of each chapter direct the reader to the relevant recommendations.

We welcome the initiative and ambition of the Scottish Government to invest in the development of social care in prisons; and Social Work Scotland for funding this report to stimulate conversations and as a driver for change. We see enhanced provision of social care in prisons acting as an accelerator for promoting better quality of life, growth and personal development in the lives of prisoners with social care needs, young and old.

1. Introduction

'This is a very welcome initiative
and very much needed'
(Integration Joint Board)

1.1 Background to Study

The absence of formalised social care in Scottish prisons is impacting on the lives of people in prison and their transition back into the community. Social care in prisons has been identified as a priority area by the Scottish Government leading to the establishment of the Health and Social Care in Prisons Programme Board. In April 2018, the researchers were commissioned by Social Work Scotland to report on the Social Care Workstream, one of four workstreams reporting to the Health and Social Care in Prisons Programme Board: Outcomes and Performance Management; Governance; Social Care and Clinical IT.

Project Aims

What are the barriers and facilitators to formalised and sustainable social care in Scottish prisons?

- ❖ **Current Context:** How is social care currently conceived, experienced and practiced in Scottish prisons?
- ❖ **Policy Context:** What are the challenges/opportunities for using current policy in prisons?
- ❖ **Future Context:** What is the vision for the future of social care in Scottish prisons?

A social work role in prisons is embedded in the *National Objectives for Social Work Services in the Criminal Justice System: Standards – Throughcare*, 2004. The Throughcare Standards detail social work responsibilities around the transition of prisoners into, within and out of prison. Recent health and social care policy developments do not extend to social care in prisons. The 2011 *SPS/National Health Service (NHS) Memorandum of Understanding* sets out the NHS and Scottish Prison Service (SPS) roles and responsibilities following the transfer of healthcare into prisons. A social care equivalent is lacking, an absence that is particularly visible in light of the legislative framework shaping health and social care integration in the community. The *Public Bodies (Joint Working) (Scotland) Act 2014* covers the integration of health and social care in the community, but not in prisons.

Person centred and outcomes-based approaches frame current social care policy and practice in the community (*Public Bodies (Joint Working) (Scotland) Act 2014* and *Social Care (Self-directed Support) (Scotland) Act 2013*), an approach that is aligned to the Scottish Prison Services' (SPS) approach to practice, which is visible in the SPS Vision¹:

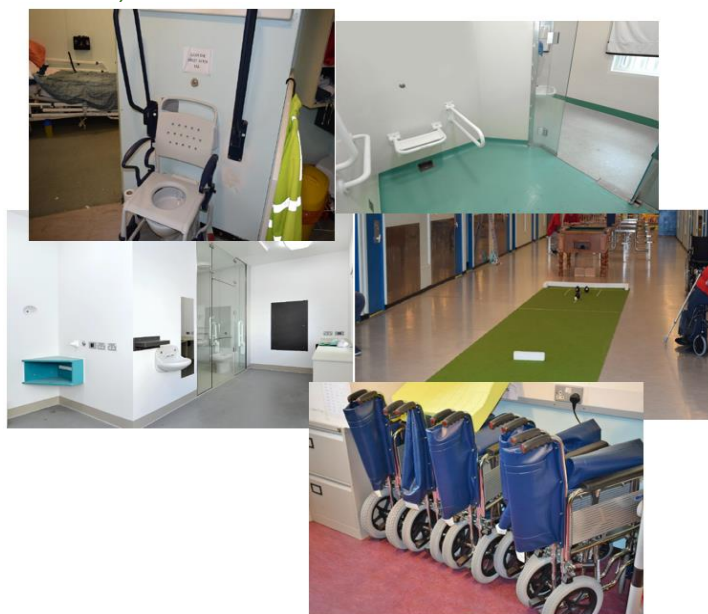
Table 1

Scottish Prison Service Vision and Mission	
1	View ourselves as part of the 'whole system'.
2	Develop a person-centred, asset based approach.
3	Promote individual agency and self-efficacy to realise potential.
4	Strengthen links into communities and support Throughcare.
5	Professionalise and invest in SPS as effective change agents.

Population estimates for the number of Scottish prisoners with social care needs, narrowly defined as personal care, are 1.85% (n = 170) of the total prison population, 0.84% of the under 50s, and 8.66% of the over 50s (Scottish Prison Service, 2018). These figures are in line with the UK Government, Department of Health modelling of social care needs in the general population (0.5% under 50s and 8.28% over 50s) (Department of Health, 2014: 81). Given the levels of health inequality and deprivation experienced by many people in prison, these figures may be a conservative estimate. In 2014/15 SPS spend on social care was £102,513.00, this is predicted to reach £852,000.00 for 2018/19 (Scottish Prison Service, 2018). This level of spending is neither a sustainable nor satisfactory answer to meeting the social care needs of people in prison.

SPS is successfully working on making their estate more physically accessible (Figure 1). This report recommends that changes to the physical structure of the SPS estate is combined with cultural change in working practices, and enhanced knowledge and understanding of working with a diverse prison population to meet the multifaceted social, psychological and physical dimensions of social care.

Figure 1 - Increasing Physical Access within Scottish Prisons (Source: Scottish Prison Service, 2018)



¹ (<http://www.sps.gov.uk/Corporate/AboutUs/Vision.aspx>)

1.2 Methodology

The project comprised three stages:

Stage 1: Literature Review: a thematic literature review was undertaken and used to inform the data collection.

Stage 2: Data Collection: qualitative data were collected from interviews in three Scottish prisons and an online survey distributed to the Integration Joint Boards.

Stage 3: Thematic analysis was used to analysis the full data set.

SPS identified three prisons for data collection and arranged access to prisoners (n = 8) and prison governors (n = 3). The prisoners had recognised social care needs and volunteered to take part in the study. All participants (prisoners and prison governors) were male and white. The interviews were semi-structured and explorative allowing for interviewees to expand on individual topics (See Appendix 3). The sample was small, but provides a timely insight into current social care provision in Scottish prisons and an empirical foundation for making recommendations on progressing social care in prisons.

The online survey was distributed by Social Work Scotland to all the Integration Joint Boards (IJB) (n = 31) in Scotland and the Director of Adult Social Care in the Highlands and Islands, where there is no IJB (collectively they are referred to as IJBs). Response rate 11 out of 32 (34%). All responses were in the form of written comments, there was no quantitative data collected (See Appendix 3). All responses were anonymous.

Grounded thematic analysis was used for data analysis. All three sets of data (from people in prison, prison governors and Integration Joint Boards) were combined for data analysis. The themes to emerge from the data have informed the presentation of the findings and recommendations.

Ethical approval for this study was received from the University of Dundee Ethics Committee and SPS Committee and SPS Research Ethics and Access Committee.

2. Law and Policy Context

This chapter discusses the broad policy and legal contexts that impact on the development of social care provision within Scottish prisons. Our study does not cover all policy instruments as that would be more suitable for a dedicated research exercise in its own right. We open with a discussion of current Scottish social care policy, before moving onto social care in prisons. The focus then shifts to consider Scottish legal instruments that could relate to the social care of prisoners, and national and international statutory and case law and the implications for social care in prisons.

2.1 Scottish Context

2.1.1 Public Bodies (Joint Working) Scotland Act 2014 and Social Care (Self-directed Support) (Scotland) Act 2013

The *Public Bodies (Joint Working) Scotland Act 2014* provides the legal framework for health and social care integration in Scotland, shaping social care policy and practice in the community. The *National Health and Wellbeing Outcomes* inform the planning and delivery of services (Table 2).

Table 2 National Health and Wellbeing Outcomes (Scottish Government, 2015)

1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities.
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7	People who use health and social care services are safe from harm.
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9	Resources are used effectively and efficiently in the provision of health and social care services.

Social care is also shaped by the *Social Care (Self-directed Support) (Scotland) Act 2013* that aims to offer greater choice and control in the lives of service users through the use of person-centred approaches, the use of which stems from the *Christie Commission* (Scottish Government, 2011). Both pieces of recent legislation centre the voice of the service user in co-producing outcomes and emphasise enhancing overall wellbeing. This requires fundamental changes in the relationships and the balance of power between professionals and service users (Kaehne *et al.*, 2017). Achieving these aspirations is not straightforward and requires new ways of working and significant cultural change in how social care is *practiced* and *experienced*. It is important to note here that the recent legal changes in the provision of social care in Scotland have *not* extended to prisons, a scenario, acknowledged by key stakeholders, that needs to be changed (**Recommendation 4**). However, the *Standards of Throughcare* (2004) already provide for a social work role in prisons.

2.1.2 National Objectives for Social Work Services in the Criminal Justice System: Standards – Throughcare (Scottish Government, 2004) (hereafter, the Standards)

The *Social Work (Scotland) Act 1968* outlines responsibility to ‘promote social welfare’ (Section 12 (1)). The *Standards* were adopted nationally to ensure that local authorities and SPS recognise their shared responsibility to provide services to prisoners. The term ‘Throughcare’ is used in this report to define the provision of social work and associated services to prisoners and their families from the *point of sentence or remand, during the period of imprisonment and following release into the community*. From the ‘point of sentence’ is salient, as the discourse of Throughcare in social work practice has largely been reduced to preparing for release from prison (most commonly in the form of providing reports for the Court or Parole Board, and attendance at SPS case management meetings). This approach neglects the need for support at the point of sentence and during the sentence, particularly for those prisoners with health and social care needs. Throughcare is conceived of as a continuum and not as an end-point (**Recommendation 5**).

The provision of Throughcare services requires an inter-professional approach with shared responsibility between local authorities and the prison service. The expectation is that prisoners should receive the same level of care as they would receive in the community. The Standards also recognise the need for prisoners to maintain their links with the services they received in the community and that this service must be delivered ‘in a manner which is efficient, fair and consistent throughout the prison system, without discrimination against race, religion, colour, gender or sexual orientation’ (The Standards (38.5)).

2.1.3 Scottish Prison Service/NHS Memorandum of Understanding, 2011

Following legislative change, responsibility for the provision of healthcare in prisons was transferred from SPS to NHS in 2011. Respective roles and responsibilities following this transfer are described in the *SPS/NHS Memorandum of Understanding, 2011* and the *Health Board Provision of Healthcare in Prisons (Scotland) Directions, 2011*. Under this new arrangement, each NHS regional agency has responsibility for the provision of health services to the prison units in their respective geographic areas. It is critical to note that the Memorandum makes clear that ‘personal and social care’ is not the remit of the NHS, but there is no equivalent memorandum to cover the provision of social care in prisons. This disparity of provision between health and social care in prisons is not aligned with the integration of health and social care in the community and needs to be addressed (**Recommendation 4**).

2.1.4 Scottish Legal Instruments that could relate to the Social Care of Prisoners

Scottish law on first sight appears to demarcate two spheres, community/society and the sphere of prisons, although the *SPS/NHS Memorandum 2011* is an example of integrated working. In many laws applicability or derogation for prisons is *not explicitly* mentioned and requires testing as to the purview of each legislation. In some instances, prisoner populations are specifically excluded (i.e. *Public Bodies (Joint Working) Scotland Act 2014*) (Table 3).

Table 3: Application of Current Social Care Legislation to Prisons

Legislation	Application to Social Care in Prison	Recommendations
<i>Public Bodies (Joint Working) Scotland Act 2014</i>	Social care in prisons is not referred to in the Act.	Extend health and social care integration to prisons.
<i>Social Care (Self-directed Support)(SDS) (Scotland) Act 2013</i>	Social care in prisons is not mentioned in the Act. Section 5 states that SDS is not available to people receiving support through probation or on release from prison, which indicates that SDS is limited to the ‘community.’	Clarification is required on the application of the legislation in the criminal justice system.
<i>Carers (Scotland) Act 2016</i>	The Act does not extend to peer carers.	The legislation could protect and support peer carers’ health and wellbeing in their caring role.

It is unclear whether there have been *Equality Impact Assessments* for prisoners (in distinction from staff) conducted by the SPS or any other body² as part of adhering to Public Equality Sector Duty, mainstreaming obligations. Additionally, NHS Health Scotland issued *‘Human Rights and*

² The researchers were not able to locate any EIA data for Scotland on the web regarding people in prisons and conclude that if this data exists the general public also would have difficulty locating it.

the Right to Health, *Inequalities Briefing #7* December 2016, which stipulates a *Human Rights Based Approach* (HRBA) to tackling health inequalities. This must extend to prisons as a consequence of the *SPS/NHS 2011 Memorandum*. The HRBA is guided by the PANEL Principles (Table 4) which must frame any work around social care in prisons.

Table 4 PANEL Principles

PANEL Principles	
Participation:	people should be involved in decisions that affect their rights.
Accountability:	there should be monitoring of how people’s rights are being affected, as well as remedies when things go wrong.
Non-discrimination:	all forms of discrimination must be prohibited, prevented and eliminated. People who face the biggest barriers to realising their rights should be prioritised.
Empowerment:	everyone should understand their rights and be fully supported to take part in developing policy and practice which affects their lives.
Legality:	use of approaches that are grounded in the legal rights that are set out in domestic and international laws.

At the time of writing there is a *Management of Offenders (Scotland) Bill – Equality Impact Assessment Record* before the Scottish Parliament. This new legislation should extend to the provision of social care for people in prisons, especially as it relates to parole advisories and transition to the community planning.

We now turn to the broader context of international legal regimes and case law as they apply to the development of social care in Scotland and corresponding factors related to compliance with human rights stipulations and standards.

2.2 International and National Statutory and Case Law

2.2.1 Jurisprudential Infrastructure

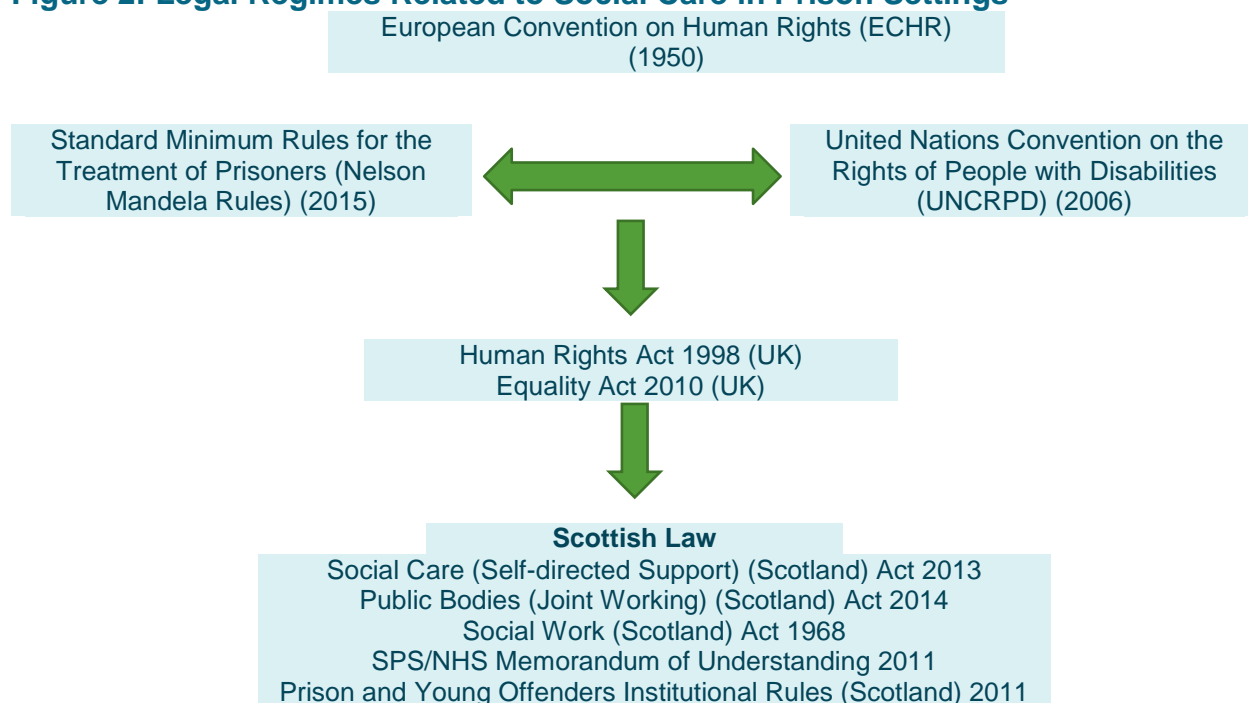
This research has identified the *European Convention on Human Rights* 1950 (ECHR) and the *UN Convention on the Rights of Persons with Disabilities* 2006, in tandem with *the Equality Act 2010* (UK) as overarching frameworks that should guide the development of social care in prisons and disability policy and law more generally. These need to be read in conjunction with the *UN Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules) adopted by the United Nations General Assembly on 17 December 2015.³ The *European Court of Human*

³ General Assembly resolution UN Doc A/RES/70/175, annex, adopted on 17 December 2015. For an overview of the process, see Tiroch, K. (2016). ‘Modernizing the Standard Minimum Rules for the Treatment of Prisoners – A Human Rights Perspective’ in *Max Planck Yearbook of United Nations Law*,

Rights has issued a number of Article 3 judgements that have a bearing on the development of social care standards (Figure 2). At a *domestic level* the implementation of social care requires clear policy about reasonable adjustment (as outlined in the *Equality Act 2010 and The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012*) as well as a uniform process of assessment, monitoring and review (**Recommendation 6**). English prisons have developed a series of policy circulars in this regard.

Of note is the requirement of Accessibility and the three-tiered approach to Reasonable Adjustments (see Section 20 of *Equality Act 2010*) and corresponding Equality Duties, as measures to promote quality of life for disabled people within and outwith prisons. Any modelling of social care in Scottish prisons must be underpinned by the requisite equality regimes, a central plank of which are reasonable adjustment measures. Such measures should be the *apex* for operationalising and measuring of individualised social care provision benchmarked with equality duties (**Recommendation 7**).

Figure 2: Legal Regimes Related to Social Care in Prison Settings



Volume 19, Brill Publishers. These rules have been incorporated by the Council of Europe (Parliamentary Assembly, Council of Europe. (2018). *Detainees with Disabilities in Europe*, Provisional version, April. <http://website-pace.net/documents/19879/4648056/20180426-DetaineesWithDisabilities-EN.pdf/8b996983-b811-4083-99e5-d32c5b5b0aaa>.

2.2.2 European Convention of Human Rights

There have been a series of Article 3 & 14 *European Convention of Human Rights* (ECHR) cases related to the conditions of care experienced by prisoners with disability. The threshold of care established by these judgements will be outlined as the jurisprudence of the Courts and have a bearing on the legal obligations of the Scottish Government's prison services. The ECHR is also given effect in UK domestic law through the *Human Rights Act 1998*.

2.2.3 Inaccessibility in Form and Provision is Inhumane

Price v United Kingdom (2001)⁴ sets the scene of establishing norms, an ethical baseline, around the provision of social care and general accessibility for disabled prisoners. In *Price*, inaccessibility (built environment and care provision) was seen to constitute a form of *degrading and inhumane treatment* and a breach of Article 3 of the ECHR. Article 3 of the ECHR, states 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment' (Council of Europe, 1950).⁵ In Article 3, discriminatory treatment can amount to *degrading treatment*. 'Degrading treatment' is defined as deliberately causing severe suffering, mental or physical' and that which 'grossly humiliates the ... individual before others or drives him [sic] to act against his conscience'.⁶ In *Tyrer v The United Kingdom* (1978),⁷ the European Court of Human Rights (ECtHR) stated that it *was enough* for the victim to be humiliated *in his or her eyes* and not necessarily in the eyes of others. The degradation involved must reach a certain level, a maximum level of severity, a relative standard considering all the circumstances of the case.⁸

In *Price*, the court concluded that inaccessibility is a form of violence against the person and constitutes a form of degradation and debasement, even if the parties to the action did not *intend* to violate Ms Price. The ECtHR found that Price's Article 3 rights had been violated despite '...any positive evidence of an intention to humiliate or debase'. Whilst there is an obligation not to inflict degrading treatment or punishment there are distinctive conditions that govern and contain this judgment, namely '... when a person has been deprived of his/her liberty by the State, the State bears special responsibility' (De Schutter, 2005, 54). The scope of this judgement was confined to custodial situations such as police stations, prisons and psychiatric institutions.

⁴ App No 33394/96, 34 EHRR1285.

⁵ The European Convention on Human Rights, ROME 4 November 1950, <http://www.hri.org/docs/ECHR50.html#C.Art3>

⁶ 12 *Yearbook of European Convention on Human Rights* 186.

⁷ *Tyrer v The United Kingdom*, (1978) (Application no. 5856/72), 17 YBECCHR 356.

⁸ It is permissible to consider the dangerousness of the prisoner in determining whether the conditions violate the Article, per *Krocher and Moller v Switzerland* (1982) 34 DR 24. (c.f. Foster, 2011, 36).

2.2.4 Autonomy Rights

In the case of *Vincent v France* (2006)⁹ the applicant, a paraplegic wheelchair user was serving a 10 year prison sentence. The prisoner had the physical ability and capacity to be able to use his wheelchair himself but complained that the conditions in which he was detained in different prisons were not adapted to his mobility needs. The Court held that there had been a violation of Article 3 on account that it had been impossible for the applicant to move around the prison as the facility was unsuited to the imprisonment of physically disabled persons who were wheelchair users. The Court considered that to detain a disabled person in a prison where s/he could not move about and, in particular, could not leave his/her cell independently, amounted to degrading treatment within the meaning of Article 3 of the Convention.

In *Z.H. v. Hungary* (2011)¹⁰ the authorities failed to provide adequate assistance to a person with multiple disabilities (Deaf, unable to use sign language or to read or write and having a learning disability), in order to inform him of the reasons for his arrest. The applicant complained that his detention in prison for almost 3 months had amounted to inhuman and degrading treatment. The Court held that there had been a violation of Article 3. Despite the authorities' laudable, but belated efforts to address the applicant's situation, it found that his incarceration without *requisite measures* being taken within a *reasonable time* had resulted in a situation amounting to inhuman and degrading treatment. *Vincent* and *Z.H* points to the imperative of autonomy of movement and communication as a vital imperative of social care.

2.2.5 Professionalism of Social Care Support

Grimailovs v. Latvia (2013)¹¹: In June 2002 the applicant, with a 5.5 years prison sentence complained that the prison facilities were unsuitable for him as a wheelchair user. The Court held that there had been a violation of Article 3. The applicant had been detained for nearly 2.5 years in a regular detention facility which was not adapted for persons in a wheelchair. Moreover, he had to rely on other prisoners to assist him with his daily routine and mobility around the prison, even though they had *not been trained and did not have the necessary qualifications*. Although medical staff visited the applicant in his cell for medical check-ups, they had not provided or organised any assistance with his daily routine. The conditions of the applicant's detention in view of his disability and, in particular, his inability to have access to various prison facilities, including the sanitation facilities, independently and the *lack of any organised assistance* with his mobility around the prison or his daily routine, satisfied the *threshold of severity* required to constitute degrading treatment. The court asserted the State has an obligation to ensure adequate conditions

⁹ App No 6253/03, EHRR, <http://hudoc.echr.coe.int/eng?i=003-1819720-1909098>

¹⁰ App No 28973/11, <http://hudoc.echr.coe.int/eng?i=002-7286>

¹¹ [2013] ECHR 737, https://www.echr.coe.int/Documents/CLIN_2013_06_164_ENG.pdf

of detention including making provision for the special needs of prisoners with physical disabilities and the State *could not absolve itself* from that obligation by *shifting the responsibility to cellmates*. This decision has implications for the development of guidelines for the usage and training of peer (prisoner) carers within SPS (**Recommendation 12**).

In *Stanev v. Bulgaria* (2012)¹² although situated within a psychiatric institution, is instructive around the issue of the *quality* of social care. This case concerned a man who claimed he had been placed against his will, for many years, in a psychiatric institution in a remote mountain region, in degrading conditions. The court observed that Article 3 prohibited the inhuman and degrading treatment of anyone in the care of the authorities, whether detention ordered in the *context of criminal proceedings* or admission to an institution with the aim of protecting the life or health of the person concerned. The court asserted that *taken as a whole*, his living conditions (the food was insufficient and of poor quality; the building was inadequately heated and in winter the applicant had to sleep in his coat; he could shower only once a week in an unhygienic and dilapidated bathroom; the toilets were in an execrable state; etc.) for a period of approximately 7 years had amounted to degrading treatment, and violated Article 3. The decision in *Stanev* has implications for the assessment of comparable living arrangements with mainstream prisoners.

2.2.6 From Reasonable Accommodations to Accessibility Duties

In the post Brexit environment where there is a lack of certainty of the status of ECHR case law, which will likely be *persuasive* rather than binding, the protection of social care rights can additionally be found in the UN *Convention of the Rights of People with Disabilities* (UNCRPD). Increasingly the ECtHR's has opted to read the ECHR together with the UNCRPD thus strengthening the *conceptual framework* of disability jurisprudence. A brief commentary about some shifts in jurisprudence which may shape future parameters of social care in prisons in Scotland is therefore necessary. The UNCRPD has two different, although related, duties of the State: one of *reasonable accommodation* (art. 5 UNCRPD) and one to *take measures to ensure access to disabled persons* ('the duty of accessibility', art. 9 UNCRPD). These duties differ with respect to their respective *rationale* and *implications*. With respect to their rationale, the duty of accessibility benefits *groups* of persons with disabilities while the one of 'reasonable accommodation' has an individual dimension focusing on a person's needs specifications. This difference is based on the fundamental observation that, even if disability captures an array of heterogeneous needs, some of them *repeatedly arise* and therefore deserve a collective (rather than an individual) answer (Damamme, 2018). Accessibility is subject to a balancing exercise between *individual rights and general interests*, and that is at the core of the ECHR system. The idea that accessibility is *anticipative* rather than *reactive* and thus potentially applicable to the

¹² App. No. 36760/06, <https://www.escri-net.org/caselaw/2016/stanev-v-bulgaria-app-no-3676006-european-court-human-rights>

entire environment of social care arrangements inside and outwith the prison is ground-breaking because of critical aspects of accessibility and its application to policy regimes and SPS/NHS budgetary planning processes (**Recommendation 7**).

Our final case *Enver Şahin v Turkey* (2018),¹³ concerns obligations for accommodations within a university setting. The case has been included here as *Enver Şahin* provides an indication of the thinking of the courts about the provision of *social care as accessibility*. As a recent judgement the case has been subjected to limited case analysis (Damamme, 2018). The university concerned argued that economic and time restraints presented difficulties for rectifying the inaccessible environment. Reading Article 14 ECHR ('prohibition of discrimination') along with Article 2 UNCRPD ('reasonable accommodations'), the Court found a violation of Article 14 as there was a (1) failure to identify *Şahin's* needs and significantly (2) there was a failure to *explore the suitability of accessibility solutions* that would provide conditions that were equivalent as possible to his peers. Damamme (2018) argues that '*Enver Şahin v Turkey* is a move towards the assessment of the suitability of solutions proposed to [disabled people] to provide them access to classrooms in light of the principles of autonomy and safety' (**Recommendation 7**).

In the context of social care in prisons *Enver Şahin* and the other cases discussed in this section radically establish the parameters and contours of obligations of the State in meeting the social care needs of prisoners, within the prison and in their transition into the community. Firmly established are the principles of autonomy rights, inaccessibility as inhumane and degrading and the professionalism of social care, which is not shifting responsibility to prisoners to undertake unpaid social care.

2.2.7 Equality Duties – Reasonable Adjustments

Reasonable Adjustments are covered in section 20 of the *Equality Act 2010*. The duty is composed of *three elements*: Firstly, section 20(3) concerns a *provision, criteria or practice* that puts a disabled person at a substantial disadvantage. Secondly, section 20(3) concerns a *physical feature* that puts a disabled person at a substantial disadvantage; and thirdly, section 20(5), but for the provision of an *auxiliary aid*, a disabled person is put at a substantial disadvantage. A failure to comply with this duty is covered under section 21 of the Act. By way of proxy, prisoners are covered under the *Public Sector Duty* requirements outlined in sections 149-157. There does not seem to be any direct provision for prisons or custodial facilities in the Act. At a national level, these duties, their operationalisation and monitoring is covered under *The Equality Act 2010 (Specific Duties) (Scotland) Regulations, 2012* (**Recommendation 7**).

¹³ App no. 23065/12. <http://www.humanrightseurope.org/2018/01/european-court-rules-against-turkey-in-paraplegic-students-university-access-human-rights-dispute/>

2.3 Recommendations: Law and Policy

Table 5

Theme	No.	Focus
Legal Frameworks	4	Framework for responsibility and resource
	5	Transition between: community-prison-community
	6	Rights based approach
	7	Equality duties and reasonable adjustment
Delivering Social Care	12	Peer carers

3. Literature Review

3.1 Introduction

A preliminary thematic literature review was undertaken to inform the data collection. This review was subsequently developed and streamlined post data collection to ensure a broader thematic scoping. A socio-cultural definition of disability represented in the 2006 UN *Convention on the Rights of Persons with Disability* (CRPD) (Campbell, 2009, Goodley, 2011, Waldschmidt, 2017), guides our study of the criminal justice system's responses to disabled offenders. Standards setting is critical in securing equalities for prisoners with protected characteristics and necessitates that the use of the UN *Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules) 2015 and the observations of the Parliamentary Assembly, Council of Europe, *Detainees with Disabilities in Europe* (2018), these have formed the backdrop for the benchmarking of our analysis. The review draws on the notion of *desistance*, of promoting prison as an opportunity for preparing people in prison, irrespective of protected characteristics, for their release from prison; with a focus on prisons reducing crime and not as warehouses of punishment (McNeil & Schinkel, 2016).¹⁴ The review first identifies characteristics of imprisonment dynamics in Scotland. Secondly, it discusses the deprivation of liberty and its consequences on health and wellbeing. The third and final section, examines social care, its definition and meaning as well as the socio-cultural dimensions of prison life that impact on social care and assessment.

3.2 Characteristics of Imprisonment Dynamics in Scotland

With an average of 140 prisoners per 100,000 inhabitants, Scotland has one of the *highest* imprisonment rates in Western Europe.¹⁵ The dynamics of imprisonment in Scotland are multifaceted. While the number of under 21-year olds in custody decreased over the past decade, an *opposite trend* has been observed in the adult prison population. One component that adds complexity to this is, that whilst the adult prison population increased, the number of crimes registered by the police declined for the same period. The most recent official published data for

¹⁴ For more on this concept, consult: *Discovering Desistance* (<http://blogs.iriss.org.uk/discoveringdesistance/>)

¹⁵ In comparative terms the Brazilian rate is 318 for 100,000 inhabitants. (Institute of Criminal Policy Research, 2018) However, when compared to its immediate peers (Western Europe), Scotland as well as England from Wales, are almost double when compared to Germany, Italy and Norway.

the Scottish Prison population is of 7,472 prisoners (SPS, 2017a). As of April 2017, there were 339 young people aged 16-20 years in custody in Scotland, 45 of whom were aged between 16-17 years, representing 4.5% of the overall prison population. Despite the declining numbers of young (16-20 years) prisoners, the majority of the Scottish prison population is *aged under 35 years* (59%), and 20% are under 25 years (Allen & Watson, 2017). The older prison population is on the rise, this changing demographic is driving much of the current interest in social care in prisons. However, the youthfulness of the population has implications for social care planning, in particular focusing on broader understandings of social care and disability. There are higher rates of disability in the prison population compared to the non-prison population being reported across the world, especially prisoners with a learning disability. On average around 30% of prison populations are likely to need some form of social care (Hayes, 1997; Docherty, 2010; Hyun, et al., 2014; Reingle Gonzalez, et al, 2016). Focusing too narrowly on the older prison population, can potentially neglect 'younger disabled people'. This may *mask* different social care needs for those under 35 years, resulting in an underestimation of forward planning forecasts of social care needs for a broader spectrum of the prison population. As the *Association of Directors of Adult Social Care* in England (ADASS) in their report *Seeing Prisoners as Assets*, argues:

While the increasing population of older prisoners is certain to generate increasing numbers with social care needs, it is important also to respond to the needs of those younger prisoners who may be living with mental health problems, a learning disability, autistic spectrum or physical or sensory disability, conditions that are less immediately apparent and therefore not always responded to appropriately. (ADASS, 2016, 4)

Even taking into consideration 'older prisoners', internationally the age range for prisoners classified as 'older' varies from 45 to 65 years, so clarity about that definition is critical (HMIP, 2004; Stojkovic, 2007, SPS, 2017b). The Scottish Prison Service (SPS) considers 50 years of age to be a 'more reasonable threshold' (SPS, 2017b, 6). Socially produced 'ageing' is apparent in general prison populations where research has shown that imprisonment accelerates the biological ageing process (Stojkovic, 2007). Furthermore, disabled people, by virtue of their socio-biological experiences of disability within the community and prison setting, experience early onset of 'ageing' and the secondary effects of their impairment.

To understand the Scottish prison system, it is necessary to analyse the conditions in which *symbolic annihilation* operates in Scottish, and more widely, British society. Symbolic annihilation (Fernandes, et al. 2018) occurs when stigmatised groups are absent from view or under-represented in a way that maintains their social inequality. Prisoners are at an extreme disadvantage in being able to generate positive social roles. Persistent negative public portrayal results in reinforced stigma. Social problems are seen as residing in individuals who are 'pathologised' through an emphasis on failure and individual blaming (Fernandes et al, 2017). In this way, people who 'orbit' the criminal justice system experience significant socio-symbolic

disenfranchisement. Any successful approach to reducing crime through imprisonment will be aligned with a *developmental understanding* of human identity, valuing people as *they are* and significantly, for what they *can become*. Central to the process of stopping offending is the development of prisoner *self-identity* (McNeil & Schinkel, 2016). Furthermore, it is necessary to consider the processes in which marginalised groups are 'pushed' into the criminal justice system, of which prison is the most extreme example. In this way, although access to health and social care is a right that should be offered to every prisoner, its implementation can, eventually, also operate alongside the prison regime to effect positive change (**Recommendation 16**). The experience of living in prison is complex and the aspects of prison quality most highly correlated with prisoner distress are safety, staff-prisoner relationships, respect, humanity, clarity and organisation, and engagement in personal development projects (Liebling, 2017, 22). This work highlights how critical it is to investigate the assumptions that underlie health and social care discourse and practice in prison and consider how this relates to the Scottish Government's more progressive (compared to the rest of the UK) approach to welfare, exemplified by *The Fairer Scotland Action Plan* (2016) with its emphasis on *inclusive growth*. The opportunities presented by Scotland having its own health, social care and legal system are however, limited by budget and broader political decisions that are not entirely devolved.

The transition back to community from prison is a critical period which involves the difficulties of navigating the support and benefit systems. Issues around GP registration, housing and benefits can be factors contributing to worsening socio-economic and health vulnerability, as well as reconviction. Research conducted by Fernandes and Sharp (2014) has shown that people affected by homelessness still face challenges when accessing welfare benefits. They face strong stigmatisation, prejudice and are an easy target for welfare sanctions. The Scottish Prison Service (SPS, 2017b, 7) highlights that 'people from the most deprived areas in Scotland are three times more likely to need care and support with activities of daily living than those living in areas considered the least deprived' (SPS, 2017b, 7). Information from agencies working with prisoners in transition show that such barriers can become a reason some prisoners reconvict. There is also evidence that welfare sanctions and conditionality has generated negative effects such as social isolation and disengagement from support networks, increased homelessness, extreme poverty, as well as engagement in crime, which strengthens the cycle of punishment by imprisonment (Fernandes and Sharp, 2014). Thus, the use of punitive measures with groups, already highly vulnerable, has shown itself to be ethically questionable and counterproductive. These measures often produce negative psychological effects that have led many to depression and in extreme cases, suicide (Watts, 2014 Cowburn, 2015)

3.3 Deprivation of Liberty, Consequences for Health and Wellbeing

It is recognized that deprivation of liberty is a factor leading to the deterioration in the overall health and wellbeing of an individual (WHO, 2003). Unfortunately some prisons are viewed as ‘places of extreme peril’ (Simon, 2014, quoted Liebling, 2017, 20). Significantly, greater degrees of mental illness, substance abuse and deteriorating physical health have been observed in prisoners than in the general population (Harris et al, 2006). Prison populations are also found to have poorer oral health outcomes (SOHIPP, 2011). Detention increases anxiety, fear and frustrations and can exacerbate pre-existing traumatic experiences. Studies by Allen (2008) and McCandless et al, (2015) confirm that up to 40 – 50% of older prisoners experience a *high incidence* of depression.¹⁶ Evidence shows that women deprived of liberty have an increased prevalence of mental ill-health compared with men (Lader et al, 2000; Harris et al, 2006; Bastick, 2008; WHO, 2009; SOHIPP, 2011). For whole of life sentence prisoners, Liebling (2017, 20) describes their experience as ‘*dying without death*’, in other words, feeling dead inside despite being clinically alive. Being unable to access basic social care may exacerbate the experience of disabled prisoners already at high risk of poor health and wellbeing.

In terms of researching and planning around social care in prisons, it is necessary to consider that data for variants other than gender, such as sexual orientation, disability, ethnicity and migration status are not consistent in the literature for the mental health of the prison population. It is imperative that *intersectionality* as an analytical tool be engaged (**Recommendation 14**) especially in the context of evaluating the performance of prisons incorporating the wellbeing of ‘protected characteristic’ groups¹⁷ as defined under the *Equality Act 2010*. Collins and Bilge (2016, 2) describe intersectionality as,

... a way of understanding and analysing the complexity in the world, in people, and in human experiences...When it comes to social inequality, people’s lives and the organisation of social power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class

¹⁶ It cannot be assumed that younger disabled people necessarily experience a high prevalence of depression, more research is required in this area.

¹⁷ What’s required is *integrated benchmarking* and standards monitoring where the protected characteristic populations are incorporated into prison assessments in an *intersectional* way, i.e. how does their situation align with the 9 Standards as defined in the *Standard for Inspecting and Monitoring* (2015) HM Inspectorate of Prisons for Scotland, rather than their population specificity, ‘disappearing’ within the archetype of a normative prisoner. See also § A 7.3. *Detainees with Disabilities in Europe* (Council of Europe, 2018).

[or age or disability], but by many axes that work together and influence each other.

With regard to children and young people, there is also the issue of inconsistency in the way ages are grouped making it difficult to draw direct comparisons across data (Harris et al, 2006).

3.3.1. The United Nations Standard Minimum Rules for the Treatment of Prisoners

The UN *Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules) were adopted by the United Nations General Assembly on 17 December 2015.¹⁸ Although the rules are not binding in the same way treaties are, they nonetheless establish the minimum standards for prisons and could be viewed as customary law (MacKay, 2017). The rules are a key framework used by monitoring and inspection mechanisms and are regarded as the primary source of standards in relation to the treatment in prison by States (Penal Reform International, 2018). Indeed, as the *Preliminary Observation 2.1* states,

In view of the great variety of legal, social, economic and geographical conditions in the world, it is evident that not all of the rules are capable of application in all places and at all times. They should, however, serve to stimulate a constant endeavour to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations. (UNODC, 2015, 1).

In the UK, the *National Preventive Mechanism* (NPM) is the body responsible for preventing ill treatment in UK prisons. The NPM is composed by 21 separate bodies that work together to strengthen the protection of people in detention through independent monitoring (Finer, 2017). In Scotland, since 2015 the *Independent Prison Monitor* is a new volunteering role for HM Inspectorate of Prisons for Scotland (HMIPS) and has statutory authority under the *Public Services Reform (Inspection and Monitoring of Prisons) (Scotland) Order 2015*. It was fortuitous that in parallel, the revised *Standards for Inspecting and Monitoring Prisons in Scotland* was launched in May 2018 by HMIPS. It is understood that the *Nelson Mandela Rules* were a relevant tool to inform the review, being acknowledged as a major international reference to improve the standards of Scottish prisons (Finer, 2017.).

¹⁸ General Assembly resolution UN Doc A/RES/70/175, annex, adopted on 17 December 2015. For an overview of the process, see Tiroch, K. (2016). 'Modernizing the Standard Minimum Rules for the Treatment of Prisoners – A Human Rights Perspective' in *Max Planck Yearbook of United Nations Law*, Volume 19, Brill Publishers. These rules have been incorporated by the Council of Europe (Parliamentary Assembly, Council of Europe. (2018). *Detainees with disabilities in Europe*, Provisional version, April. <http://website-pace.net/documents/19879/4648056/20180426-DetaineesWithDisabilities-EN.pdf/8b996983-b811-4083-99e5-d32c5b5b0aaa>.

3.3.2 General Characteristics of the Health Conditions of the Scottish Prison Population¹⁹

The socio-economic profile of the prison population is internationally recognised as socially vulnerable and comprising individuals from communities with social and health indicators more precarious than that of the general population (WHO, 2014). In the Scottish context, there is public recognition of these problems, something that has been acknowledged by the Government as a challenge in the context of the reduction of ‘health inequalities’. It is important at this point to ensure that we do not confuse health needs which arise from biomedical origins, and the social care needs of prisoners which arise from multiple and varied sources. In order to fully enable people with a disability our focus must be on promoting independence and self-determination, acknowledging that disability is an *evolving concept* that is in constant interaction with the environment. As the Preamble of the *UN Convention of the Rights of Persons with Disabilities* [UNCRPD] states:

... disability is an *evolving concept* and that disability *results from the interaction* between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others. (*Convention on the Rights of Persons with Disabilities*, 6 December 2006, at [e], emphasis added).

It cannot be assumed that disabled people are *automatically* unhealthy or have a health condition and, conversely, that there are prisoners who have a health condition who would want to be identified as disabled or who view themselves as disabled. These conceptual confusions potentially have real life implications in everyday interactions and professional practice. If a medical focus is replaced with a broader more holistic one, the process of making assessments and delivering services would lead to a different understanding of the ‘problems’, leading to alternative, perhaps quite innovative, solutions. ‘Ill health’ is often cited as the major reason for not feeling able to take part in prison activities (SPS, 2017b). To more fully understand and address why prisoners are not taking part in activities requires in-depth exploration of the framing and language used to facilitate for a more nuanced explanation of the person’s situation, i.e. in what way does the prisoner’s own understanding of disability or the availability of supports effect how able they feel to participate or ask for help or adjustments to participate in activities?²⁰ **(Recommendation 1 and 2).**

¹⁹ The information presented here is a summary of Scottish Parliament (2017) and Royal College of Nursing (2016).

²⁰ This is particularly important for prisoners who acquired their disability whilst in prison, who are likely to not have accessed rehabilitation, independent living training or specialist disability counselling, as would most disabled people living in the community.

Some critical areas that affect the health and wellbeing of people in prison have been identified which include alcohol, drugs, tobacco, oral health and mental health. The prevalence of chronic health conditions, such as cancer, diabetes, respiratory problems and cardiovascular diseases were also acknowledged (Graham, 2007). There is significant evidence that people in prison have high rates of traumatic head injury (Pitman et al, 2015, Williams et al 2010) and many have needs related to trauma from Adverse Childhood Experiences (ACEs). The Welsh study (Bellis et al, 2015) found that individuals with four or more ACEs were four times more likely to be a high risk drinker, six times more likely to be a smoker, 16 times more likely to be a crack cocaine or heroin user, 15 times more likely to have been involved in violence in the past year and 20 times more likely to be in prison during their lives. In this review we highlight two key areas:

3.3.2.i. Mental health and wellbeing

The report of the Scottish Parliament's Health and Sport Committee, *Healthcare in Prisons*, estimated that approximately 70% of the Scottish prison population will develop a mental health challenge. However, access to health and counselling support services for treatment and 'recovery' are not considered sufficient (Scottish Parliament, 2017). The British Psychological Association, for example, reports that the standard window of no more than 18 weeks for treatment in the community does not apply to prisoners (Scottish Parliament, 2017). The Royal College of Nursing, also argued for the need for better provision of clinical psychology and improved links with community services, as well as highlighting a lack of specialised services for adolescents (Royal College of Nursing, 2016). In addition, there is a gap in the systems of evaluation of prisoners' mental wellbeing, a limited number of diverse professionals dedicated to mental health, and insufficient investment (Royal College of Nursing, 2016). The issue of mental health has also been a matter of criticism by Her Majesty's Inspectorate of Prisons Scotland (HMIPS), which has raised concerns about the number of people with mental health challenges kept in prisons due to a lack of psychiatric treatment available in the community (Scottish Parliament, 2017). The Health and Sport Committee argued that prisons have no alternatives but to accept detainees until they can be transferred to appropriate treatment facilities (Scottish Parliament, 2017).²¹

3.3.2.ii. Alcohol and Drugs

A large number of prisoners experience drug and alcohol related problems. In the 12 months preceding the parliamentary report *Healthcare in Prisons* (Scottish Parliament, 2017), it was reported that nearly 5,500 prisoners began treatment for drugs and alcohol related issues. The waiting time to begin treatment is considered to be very good, with almost 98% waiting less than

²¹ We can only speculate if individuals are being transferred, given the lack of clarity on prisoner mental health assessments. This issue demands further investigation, including the degree of influence mental health (and broadly 'mental wellbeing', which can be deliberately vague) can have on sentence outcomes.

three weeks, in accordance with the Scottish Government's *Local Delivery Plan Standard*, with 77.5% waiting a week or less (Scottish Parliament, 2017). We question the emphasis given to the treatment of addictions, since the standards of medicalisation imposes a disproportionate burden of work on a narrow range of health professionals (doctors and nurses), who are responsible for the administration of medication, in contrast with an *inter-professional orientation* engaging with social workers, art therapists, meditators and occupational therapists. The *Healthcare in Prisons* report indicates that professionals spend about 40% of their time exclusively on the distribution of medications, depending on the number of prisoners in treatment (Scottish Parliament, 2017). As a result, other demands end up not being met, creating an imbalance in the provision of health and social care. This issue raises the question of the growing process of medicalisation of prisoners, creating another level of drug dependency.²² Of note, is the fact that the *Equality Act* (2010) does not include drug dependency as an independent element, as conforming to the definition of disability within the Act.

3.3.2.iii. Missing Masses

Keeping in mind the previous comments about a reductionist approach to social care to solely health needs leading possibly to false or narrow strategies about needs and the goals or desires of people in prison, a review of disabled prisoners in England and Wales by HM Inspectorate of Prisons (HMIP, 2009) found that the provision of social care and purposeful activities for disabled prisoners was uneven with the needs of a significant number of disabled prisoners being unmet (**Recommendation 1 and 15**). The review also found that approximately 1 in 3 prisoners with a disability in English and Welsh prisons had been identified by the prison service. Of concern, this figure contrasts sharply with *self-reported* disability rates of 15% in those same prisons. There are significant issues regarding official statistics and prisoner's *own perception* of identifying as disabled. People with diagnosed or borderline learning difficulties (i.e. dyslexia) or learning disabilities (previously referred to as intellectual disability and/or brain injury) regularly end up in the prison system but are not readily identifiable to themselves and prison staff. Consequently, these prisoners are unlikely to receive the health, social care and educational support they need, even in instances where specialised support is available (Hyun et al, 2014; Kirby & Saunders, 2016; New & James, 2014; Talbot, 2010; and older research by O'Brien, 2008; Myers, 2004). Despite this invisibility, O'Brien argue that 'on any given day about 500 prisoners will have IQs in

²² This is another area that demands further investigation in order to understand the wider process of medicalisation of prisoners, the everyday decisions that are driving health practice, and the pressures arising from the penalisation mind-set potentially have on the administration of controlled drugs to keep prisoners calm and under control. There is also the issue of drug administration, with prisoners reporting that some drugs are administered in the 'wrong way' as a security measure. The key point is to identify how the security routine impacts on health and social care.

the range of a technical learning disability, while an additional 1,400-1,750 will require some additional support' (O'Brien, 2008, 3).

In Scotland, prisoners' self-reportage was higher than in England and Wales, with 19% of prisoners in Scotland identifying with disability²³ (Carnie and Broderick, 2011). The *2017 SPS Prisoner Survey* indicates that since 2011 the number has *grown* to 34% (Scottish Prison Service, 2017c). This increase can partly be explained by the rise in older prisoners, but is still likely to be a *conservative* estimate related to prisoners feeling able and willing to be associated with a protected characteristic. Scottish research by Myers (2004) revealed that formal assessment and diagnosis of a learning disability or learning difficulty in secure settings is rare, yet *coal face knowledge* indicates that prison staff and managers believe many such people are in custody (Hyun et al, 2014; Kirby & Saunders, 2016) (**Recommendation 11**).

3.4 Social Care (Recommendation 1, 2 and 13)

In this section of the review we focus specifically on social care as a concept and as a practice. We focus on the prison system within Scotland and internationally to explore the socio-cultural dimensions of prison life that have relevance to the practice of social care including the conceptualisation of disability and chronic illness as a form of difference (**Recommendation 13**).

3.4.1. Definitional Conundrums?

As a starting point for discussing how social care is practised in prison relevant stakeholders need clarity around terminology. A dominant narrative throughout the literature is the *absence* of definitional consistency around defining and conceptualising social care. As a consequence there is a lack of social care in prisons (Williams, 2012; O'Hara et al, 2015), confusion over roles and responsibilities to support prisoners (Senior et al, 2013; O'Hara et al, 2015), and prisoners' legal right to social care are being denied (Walsh et al, 2014).

Overall social care has been defined in overly limited terms, largely related to a narrow remit of personal care, supporting 'Activities of Daily Living' (ADL), e.g. eating, mobility, toileting, dressing. This approach aligns with the medical model of disability and reflects a societal wide unconscious bias about the nature of disability. It does not take into account more recent conceptual modelling of disability such as the social model of disability (Oliver, 1990) and ableism (Campbell, 2009; Goodley, 2011; Waldschmidt, 2017). Nor does a medical model approach align with the UNCRPD which is framed by the social model of disability and the removal of physical, structural and attitudinal barriers in society (Oliver, 1990) (**Recommendation 2**). A key issue that emerges from

²³ The *Census 2011* suggest 20% people report a disability that impacts on daily life.

this review is the significance of the *social dimensions of prison life*. This aligns with a broader understanding of social care (**Recommendation 1**) including wellbeing and the need to adopt approaches to support people to have agency and meaning in their lives. This broader approach to social care links to the SPS vision (Table 1) (**Recommendation 1 and 15**).

The *Dilnot Commission* defined social care inclusively as follows:

Social care supports people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people to sustain employment in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society. (Commission on Funding of Care and Support, 2011).

In England and Wales, the sentiments of the *Dilnot Commission's* definition of social care is established via *The Care and Support (Eligibility Requirement) Regulations 2015* which specifies the outcomes that may be addressed in care and support plans and written information. The remit is clearly broad, encompassing *purposeful activities* beyond the narrow remit of *Activities of Daily Living* (ADL) (**Recommendation 1 and 15**). In a prison setting social care includes: managing and maintaining nutrition; maintaining personal hygiene/managing toilet needs/being appropriately clothed; being able to live in a cell safely/maintaining the cell as a habitable environment; developing and maintaining personal relationships; accessing and engaging in work, training, education or volunteering; and making use of facilities or services in the prison, including recreational facilities or services.

Social care extends to beneficiaries *beyond* the disabled prisoner and includes other prisoners, prison staff, governments in terms of promoting better health and productive lives for its citizens, as well as the wider community. On the basis of this review, we have developed an *empowering approach to social care* based not only on the social determinants of health but also enabling social inclusion (Table 6).

Table 6

Six Principles of Empowering Social Care	
1	Achieving outcomes for a meaningful life should be the driver for social care.
2	Person centred approaches should be embedded in social care, ensuring service users are listened to and included in co-producing outcomes.
3	Disability is not just a diagnostic phenomenon, it is highly individualised and evolves over time.
4	Human wellbeing and individual lives involve complex and changing dimensions, social care needs to be cognisant of service users' inner (psycho-social) and outer (social) worlds.
5	Integrated working requires understanding and collaboration between professions and service users.
6	Oppressive, thoughtless and unjust attitudes and practices should be challenged and addressed.

3.5 Socio-cultural Dimensions of Prison Life

3.5.1 Relationships and Social Isolation

The message from research stretching from Ghana to the US, Norway to Scotland, is that prisoners with social care needs are more likely to experience social 'isolation' and 'loneliness' than non-disabled prisoners (Jang and Canada, 2014; Haualand, 2015; Dogbe et al, 2016; Stevens, 2018). A report on American prisons by Disability Rights Advocates (2012) argued that disabled prisoners 'essentially live in solitary confinement'. Some innovative work in English prisons using *Therapeutic Communities* engages with the social and psychotherapeutic aspects of prisoners lives that, Bennett and Shuker (2016) evidence, positively impacts on wellbeing and recidivism. Prisons, despite being custodial, can be transformed into caring environments, as Bennett and Shuker (2016, 21) put it:

The notion of a democratic Therapeutic Community (TC) located within a prison is atypical, and may even seem countercultural ... offers something markedly different to that found in other penal settings ... they provide the context in which prisoners come to think that personal change is a reality.

In 1962, HMP Grendon, located in England, was the first democratic²⁴ Therapeutic Community (TC) prison. Grendon has a 20-place unit for learning difficulties (mild/moderate) but is integrated with the rest of the prison for activities. Prisoners need to volunteer and apply to be accepted in the community and service provision is largely by staff employed by the prison but also some private health providers. The management of these communities is premised on constructive positive relationships, a culture of visits and decency, trust and safety (Rawling 1998; Bennett and Shuker 2017). Prisoners are involved in meetings, planning and decision making. The outcomes of these communities, which have been regularly reviewed, include increased self-esteem, a reduction in anxiety, lower reconviction and greater engagement of staff and prisoners. Given the enduring success of HMP Grendon, calls have been made for the European Union to encourage the development of a pilot and evaluation of the Grendon model in each EU member state (Cretenot, 2013, 32) (**Recommendation 2, 10 and 16**).

In prisons without these innovative interventions, the main types of prisoner relationships are: (1) family and friends outside of prison, (2) other prisoners and (3) prison staff. Maintaining a

²⁴ Therapeutic communities tend to adopt either a democratic model or hierarchical model (common in the USA), see Rawlings (1998). HMP Dovegate, a private prison in England has a 200 bed democratic therapeutic community located in buildings detached from the main prison, (Crewe, et al, 2015, 314).

relationship with family and friends appears to be the most significant, and the most difficult to sustain (**Recommendation 16**). These relationships are challenged when prisoners are placed in prisons far from their home and established support network of family and friends, or when these networks are cut in response to a conviction. A recent report on social care and older prisoners in Scottish prisons highlighted the importance of relationships with loved ones, and that the loss or lack of these reveals a ‘deep sadness and hopelessness’. In the words of one prisoner:

I don't get any visits, my family have disowned me and I don't have anyone in here I would call a friend. What's the point? (Prisons Inspectorate, 2017, 11)

The gravity of this issue is recognised in international policy and national health strategies (World Health Organisation, 2002, see Lucas et al., 2018). There are examples of good practice from around the world of ways to address the need for prisoners to maintain contact with family, friends and society outside of prison. The Norwegian system of small, local prisons ensures that ‘prisoners serve their sentences as close as possible to their social network and relevant service providers’ (Pratt, 2008, cited in Gisler, 2018, 30). A system in Canada has improved the social contact of prisoners with the outside world through a successful pen pal programme (Gisler, 2018). In Switzerland, the fostering and sustaining of social support networks is being supported by making it easier for family and friends to visit prisoners (Handtke et al., 2014). Boodle et al (2014) paint a less optimistic picture for prisoners with learning disabilities in Australia, they argue that prisons lack the resources to meet the particular needs of this population, leading on release, to people ending up back in ‘the community with little or no rehabilitation, poor social connections, poor mental health and little chance in finding employment and living a crime-free life’ (**Recommendation 16**).

Central to discussions around social care is how the person being supported *perceives* and *accepts* that support. Peer caring, through prisoners supporting each other, is a growing reality in prisons and one that needs attention as it is a complex and contested issue (**Recommendation 12**). How a prisoner identifies and accepts the need for social care influences the ease with which they will connect and build relationships with other prisoners. The converse can happen where inaccessibility in its broadest sense in turn produces injurious practices:

In a prison environment that is punitive and fails to accommodate a person's disability, prisoners with disabilities often struggle to cope and their resulting behavior is misunderstood by staff. Prison staff acknowledge that people with disabilities can be overrepresented in detention units and that they are not adequately trained on disability and mental health to distinguish between a conduct that stems from the disability or a mental health crisis and one of defiance. (Human Rights Watch, 2018, 71-72).

Developing a disabled identity is something that many prisoners resist, which impacts on their relationships with other prisoners and sources of peer care (Williams, 2012; Hauland, 2015; SPS, 2017, 29). For those prisoners that don't have meaningful relationships with family and friends outside of prison nor with fellow prisoners, they likely turn to prison officers to meet that level of human need and interaction, 'without caring staff, some elderly prisoners would have no one who cares about them at all' (Prison Inspectorate Scotland 2017,13). Prisoners want 'respectful relationships with staff' and to be 'listened to and understood' (Ironside, 2015; SPS, 2017c, Prison Inspectorate Scotland 2017).

3.5.2 Prison Culture and Working with Difference

Uniformity of regime leads to good order and avoids the perceived risks created by diversity. However, the basis of this argument is administrative convenience rather than necessary implication. (Williams, 2012, 482)

The socio-cultural-political landscape of disability is slowly changing norms and practices in a range of areas. However, in prisons, acknowledging the need to adapt and work with difference has been slow in gaining traction and momentum (Ironside, 2015). Crawley's (2005) work introduced the concept of 'institutional thoughtlessness'. In essence, her work argues that prison regimes and structures have failed to recognise and adapt to the needs of different prisoners. Prisons, put simply, are designed for men, who are young and non-disabled, and who do not have other protected characteristics (Aday, 2003; Bartlett, et al, 2014; Handtke et al, 2014; Jang and Canada, 2014). Prisons work around uniformity, the 'sameness' principle (Williams, 2010), which risks disabled and older prisoners being vulnerable (Williams and Atthill, 2005 and Docherty, 2010), especially when prison officers don't acknowledge or think they need to be involved with addressing difference (Crawley, 2005) (**Recommendation 13**).

3.5.3 Rights and Equity of Experience

Prisons offer a range of activities for prisoners, including working, studying and exercising, but it is clear that disabled and older prisoners are *less likely* to access and participate in these activities than non-disabled and younger prisoners (Reingle Gonzalez, et al, 2016). This impacts on prisoners in a variety of ways, including excluding them from social interactions. The reasons as to why prisoners are not taking part in these activities are interconnected with the absence of social care in prisons and raise questions around the support and accommodations that are being made that either enable prisoners to participate or further disable and isolate them (**Recommendation 1 and 15**). Prisons appear to be framing their practice within a medical model, situating the 'problem' with the individual and not the structures and culture of the environment (**Recommendation 2**).

I enjoy working and keeping busy.

I was told that as I walk with a walking stick I was a risk to myself and other prisoners.

Client advised that she would like to go to the gym but is too anxious to attend and that she finds social situations, even going for lunch, very hard. (SPS, 2017, 20)

There are suggestions of how small, simple changes can make prison activities more inclusive, for example, providing more chairs in an exercise yard (Walsh et al, 2014). An example of alternatives in one Scottish Prison was teapacking (Ironsides, 2015), although this activity was later replaced. There are limited examples of disabled prisoners involvement in purposeful activities, which highlights the challenges of the prison environment to support social interaction and involvement in meaningful activities. Without more inclusive activities this cohort of prisoners are, in effect, receiving *harsher* sentences than non-disabled and younger prisoners, a *Confinement within Confinement*, jeopardising their wellbeing and their rights (Talbot, 2010; Williams, 2010; Disability Rights Advocates, 2012; Hauland, 2015; Dogbe et al, 2016;). Hauland (2015, 74) argues that in theory the Norwegian prison model is based on, 'deprivation of freedom, not the prison conditions, as the punishment for crime'. The same discourse appears apparent in Scottish social policy but needs to be more visibly woven into the prison regime and social care practice in prisons (**Recommendation 1, 2 and 15**).

3.6 Procedural Dimensions

The more closed a system is, the harder it will be to return to freedom
(Gisler, 2018, 31)

3.6.1 Responsibility for Provision of Social Care

Current social care policy in Scotland is framed by the *Social Care (Self-directed Support) (Scotland) Act 2013* and the *Public Bodies (Joint Working) Scotland Act 2014*. Core to both is that practice should be person-centred, facilitate for choice and control and co-produce outcomes that have meaning to the service user. This requires *new ways* of working and *significant cultural change* in how social care is practiced and experienced in the community and, by implication, in a prison environment. Fundamentally the relationships and the balance of power between professionals and service users' needs to evolve (Kaehne *et al.*, 2017). Applying these concepts in a prison context, particularly in the absence of any Scottish legislation that clearly defines

responsibility and approaches to providing social care in prisons, is challenging **(Recommendation 4)**. The SPS vision includes developing ‘a person-centred, asset-based approach’ and there is a recognition of the need to start working more collaboratively with prisoners, to change the prison officer-prisoner relationship and to take into account the views of prisoners to co-produce outcomes. Good relationships ‘can only be achieved by working in ways which are centred on the individual’ (SPS, 2013, 11; Ironside, 2015, 76) **(Recommendation 8, 9, 10 and 13)**.

In Norway, what is referred to as the *Import Model* asserts that the prison service is responsible for security and correctional aspects; whilst healthcare, education and employment services are provided by external agencies (we note there is no explicit reference to social care provision). The manifest strengths of the Norwegian approach are summed up by the Norwegian Correctional Service (NCS): ‘This model assures continuity of services upon release and cross-sectoral involvement in the rehabilitation of offenders’ (NCS, 2012, cited in Gisler, 2018, 30). Any activity and strategy undertaken by the NCS is unpinned by *five pillars*, namely:

1. Legislation
2. Humanist approach
3. Principles of due process and equal treatment
4. Debt to society ends with the end of the sentence
5. Principle of normality – influences the overall culture:
 - a. Punishment means the restriction of liberty where no other rights shall be affected.
 - b. No one should serve their sentence under stricter circumstances than necessary.
 - c. Life in prison should correspond as much as possible to life outside – includes legislation in relation to health (NCS, 2016; Gisler, 2018, 30)

In England, the *Care Act 2014*, clarified that responsibility for providing social care lies with the statutory authority where the person is ‘ordinarily resident’. Statutory authorities provide social care to prisoners in the broader context of statutory authorities already being stretched, due to budget cuts and austerity measures. As Humphries et al (2018, 3) report the:

Central government grant reductions to local authorities have been passed on to care providers in the form of reduced fees, or below inflation increases. Combined with shortages of nurses and care workers, higher regulatory standards and the introduction of the National Living Wage, this has put many social care providers under unprecedented pressure.

As O’Hara et al (2015, 279) note, ‘the ‘ordinary residence’ rule is a very effective barrier to provide social care’, and they go on to point out that, ‘statutorily provided social care is often non-existent in prison, due to the lack of understanding of what it constitutes and who is responsible for its provision’ **(Recommendation 5 and 16)**.

The nature of the prison environment currently prevents regular access for external staff during lock down overnight but shouldn't prevent access during the day. This is another factor that can significantly affect people in prison accessing the care that they need. The main narrative is that social care in prisons is markedly inferior to what is provided in the community (Williams, 2010; O'Hara et al, 2015). Where there is no dedicated provision of social care, responsibility is left to healthcare staff (instead of social work/social care staff), or more likely other prisoners or prison staff. In the SPS 2017 Prisoner Survey (SPS, 2017c), prisoners noted who they received support from. Fellow prisoners provided the most social care (43%), followed by prison officers (40%) with healthcare staff providing the least (17%). Important to note here is that there is no mention of social care or social work (Table 7) (**Recommendation 8**).

Table 7 Scottish Prison Service Prisoner Survey 2017

Source: (SPS, 2017c)

Do you require assistance in the following daily activities?		Yes	No	Total (n)
Transferring/moving around the prison		7%	93%	2666
Washing/personal care		4%	96%	2597
Toilet use		2%	98%	2569
Dressing		2%	98%	2569
Collecting meals		4%	96%	2578
Eating meals		2%	98%	2559
If yes, were you given help/assistance?		24%	76%	2659
If yes, who helped you?	Healthcare Staff			
		17%	43%	40%

3.6.2 What Place, Prisoner/Peer-Carers?

Peer-support has existed in prisons both in the UK and overseas for decades, primarily in the form of discernible yet informal listening 'programmes' or 'schemes' (Fletcher and Batty, 2012; Jaffe 2012; South et al, 2014; Her Majesty's Inspectorate of Prisons HMIP, 2016). Through these programmes, prisoners are able to access support from fellow prisoners for issues ranging from emotional distress and addiction problems to practical and educational needs (Stewart, 2011; Loeb, 2013). A prisoner/peer carer is defined as 'a prisoner who is employed or formally working in a social care role; activities may include low level care activities such as befriending, fetching meals and helping other prisoners to tidy their cells', 'wheelchair ambulation, encouraging out-of-cell activities, social interaction, assistance with administrative activities ..., purchasing items from the canteen and advocating on their behalf' (Stewart and Edmund, 2017, 45) (**Recommendation 12**).

The literature on prisoner/peer caring is mixed. Collica (2013, cited in Stewart and Edmund, 2017) talks of the positive benefits of prisoner care providing a means of emotional support that can be very beneficial in developing a sense of identity, community and reducing the impact of institutionalisation, but this is dependent on prisoners having peers they can trust (SPS, 2017c). Stewart and Edmund (201, 45) argue that peer caring is particularly beneficial for older prisoners who 'prefer to be cared for by their peers'. For some prisoners, pride, identity, independence are all interconnect preventing them from accepting or asking for peer support (Ironsides, 2015). Finding support is not straightforward. 'If you're a wheelchair user, you'll struggle to get anyone to push you to visits, health centre, agents, library etc., without having to bribe someone' (SPS, 2017c, 35). O'Hara, et al. (2015) raise questions over the choice and control prisoners have over who supports them (**Recommendation 10**). Despite these interventions, research about the efficacy of peer support programmes is almost non-existent. There appears to be a gap in the operation of programmes covering the *Disability Experience*. The objective of the peer support social movement which emerged from mental health patient advocacy was, and is, to encourage mental health service users to share their experiences and help each other in ways that professionals would not be able to. Peer support in community social care settings therefore has perhaps flourished due to resource constraints or professionals' lack of ability to empathise on an experiential level with disabled people (Davidson, Bellamy, Guy, & Miller, 2012). Generally, research supports the premise that peer-support programmes represent a unique and valuable form of support, principally due to the reciprocal empathy dynamic that underpins it. Research has consistently revealed positive effects resulting from peer-support schemes in marginal and vulnerable communities and would hence be beneficial for disabled prisoners (Jaffe, 2012; Walker & Bryant, 2013). A *Disability Experience* would promote greater fellowship amongst disabled prisoners. This work highlights the scope for supporting group peer mentoring programmes run by disabled people or disabled ex-offenders being offered in prisons (**Recommendation 2 and 12**).

The use of 'passmen' being allocated to prisoners in Scottish prisons for, amongst other things, cleaning cells, collecting of meals and wheelchair pushing, led Ironsides (2015, 56) to conclude that 'prisoners found these services wanting or indeed wanted them on their terms' to exercise agency over who was supporting them. Fletcher & Batty (2012) in broadly examining general peer support programmes found that the motives of prisoners providing peer support were complex and oscillated between altruism and self-interest. Sometimes 'motivation can also take more prosaic forms. It was reported that some are merely lost for things to do and want to establish a daily routine' (Fletcher & Batty 2012, 10). In these circumstances, there is a situation where other precarious prisoners with their own issues could be placed providing support to disabled prisoners who experienced greater degrees of powerlessness. The question of 'choice', Tucker et al (2017, 15) argue, equally applies to prisoners providing care, arguing that there is 'a potential concern that prisoners might feel they have no other option but to accept such help from other prisoners – a situation that would not be permissible in any analogous community-based institution.' Issues

of ethics/risk/abuse can't be excluded from discussion of peer caring (O'Hara, et al., 2015; Stewart and Edmund, 2017) **(Recommendation 10 and 12)**.

The English based study by O'Hara et al (2015) highlights that peer carers are involved in 'inappropriate' personal care, when professional support should be available. 'Oh you [social care worker] shouldn't have to do that [change incontinence pads]. Just leave ... we'll get the prisoners to do that' (O'Hara, et al., 2015, 278). The impact of austerity measures and staff cuts have resulted in an increase in the use of prisoner carers which as the Independent Monitoring Board (IMB) noted increases the possibility of increased risk and precariousness: 'While the prisoners who do these tasks carry out at times an unenviable role there will always be risks attached, a possible one being taking medication belonging to prisoner being cared for and as in the community there is always risk of abuse of a vulnerable individual' (IMB, cited in McHugh, 2017). Such scenarios, rather than social care being an opportunity to realign power relations between prisoners and prison officers to co-produce outcomes, are reproducing the status quo. The *National Offender Management Service*, in its policy on '*Prisoners Assisting other Prisoners*'²⁵ established 8 Principles that guide assistance (See *Appendix 2*). Any social care system needs to tackle complex issues around the *reciprocity of assistance* including ways that disabled prisoners can make contributions to the prison community and not just be seen as infirm²⁶ or in/valid. Unfortunately, good practice in prisons still relies on 'the efforts of individuals rather than integrating disability work fully into core business' (Cooper, 2011, 18). This proactivity is critical in developing strategies for staff as well as disabled prisoners to deal with disability discrimination and hostilities from (non-disabled) prisoners **(Recommendation 2, 3, 10, 12)**.

3.6.3 Prison Officer Carers?

Ironside who is a researcher and a prison governor, provides an example of good practice of peer caring, with prison officers working collaboratively with the prisoners to achieve prisoner-staff co-production. 'This is a complete shift of the prisoner/officer paradigm where staff not only depend, but respond to another prisoner's assessment of another prisoner's condition' (Ironside, 2015, 65). On the other hand, Crewe et al (2015) argue that prison officers perform an essential *gatekeeping* role in accessing institutional and social resources. Prison officers carry out a pivotal function as a *mediator* between the State and prisoner. In that sense, they argue that prisoner's need to be 'attuned to the tense dynamics of prison life' (Crewe et al, 2015, 347). In their study of staff-prisoner relationships in both private and public prisons, the researchers came to two conclusions relevant to this project. First, that there is not necessarily a correlation between being

²⁵ PSI/2015, (2016).

²⁶ We would suggest that terms such as *infirm* and *feeble* be restricted in use to describe a disabled person as such terms carry with them certain assumptions about capacity. The vast majority of disabled people, even those with learning disabilities or dementia are able to contribute to prison life in some way despite experiencing 'deficiencies' in some aspects of their functioning.

'nice', having a good rapport with prisoners and having appropriate skills and training. Secondly, prisoners report that even when there are positive relations with prison officers, this positivity does not necessarily *translate* to a sense of prisoners feeling secure and having clarity about prison rules and processes for accessing services (Crew et al. 2015). Tait's (2011) work usefully provides a *typology of prison officers* approaches to caring for prisoners:

- **True carer** – confident, secure and highly engaged in their work, viewed prisoners as people with needs, respected and protected prisoners' agency, actively resisted negative stereotyping of prisoners. However, this could lead to them being bullied for 'cultural deviance' (Tait, 2011, 452).
- **Limited carer** – procedural in approach to care, did what was necessary, viewed prisoners as socially vulnerable group.
- **Old school** – clear distinction between us and them, limited emotional support, but genuine commitment to helping prisoners.
- **Conflicted** – caring involved teaching prisoners to be better people, conflated care with control, saying no was for their own good, care was conditional on prisoners being 'deserving' – prisoners seen as needy – maintained dependency.
- **Damaged carer** – damaged officers through years of work, no longer able/wanted to take on caring role.

The range of caring roles described by Tait (2011) point to tensions and ambiguity over the prison officer role. Clarity is needed to progress the social care agenda and address the challenges of staff embodying new approaches to their practice that risk 'cultural deviance' (Tait, 2011, 452) when the aim is cultural change (**Recommendation 9 and 13**).

3.7 Assessment (Recommendation 11)

This section discusses aspects related to health and social care assessments, focusing on (1) the nature of assessment instruments, (2) points in time assessment needs to take place and finally (3) the composition of professional assessment teams.

3.7.1 Assessment Instruments?

Within the UK a variety of assessment instruments are used to ascertain the needs of all prisoners. Their usage seems to be somewhat haphazard and are dependent upon national and local guidance. The *National Institute of Health and Care Excellence* (NICE) recently issued guidance recommendations in the form of two documents, one general '*Physical Health of People in Prison*' - NICE Guideline 57, (NICE 2016) and another with a specific focus on mental health,

'*Mental health of Adults in contact with the Criminal Justice System*' NICE Guideline 66 (NICE 2017). Both NICE guidelines establish a good *baseline* for an overall health assessment but are *insufficient* in assessing for social care and disability reasonable adjustment requirements and thus require some degree of *supplementation*. Bradshaw et al (2017) outlines a two-stage process: first stage, general health assessment, and second stage, a following assessment undertaken within seven days of admission to prison. Whilst the first stage is comprehensive incorporating primary health needs it only touches briefly on living arrangements failing to conduct an environmental audit for the prisoner being assessed. Although both NICE guidelines include social care, educational and occupational needs as part of the assessment, the enquiries are framed within a narrow health paradigm. Significantly, the NICE guidelines specify the necessity to identify 'a clear strategy to access all identified interventions and services' (Bradshaw et al, 2017, 4).

In England, the University of Manchester developed the *Older Prisoner Health and Social Care Assessment and Plan* (OHSCAP). Developed through action research, including prisoners, the OHSCAP systematically identifies and addresses the health and social care needs of older prisoners, through improved assessment, care planning and subsequent service delivery (Walsh et al, 2014). This is intended to result in a reduction in health and social care needs and improvements in health symptoms and social care problems. The intervention: the OHSCAP is a structured approach for better identification and management of the health and social care needs of older prisoners. The instrument is a paper-based tool consisting of an assessment, subsequent care planning and reviews. The *Older Prisoner Lead* [OPL] (prison officer) coordinates the assessments with the older prisoner seven to ten days after prison entry. The OHSCAP incorporates inquiry around relationships, activities, mobility, emotional wellbeing, physical wellbeing and release planning, moving beyond and a health condition assessment towards a holistic appreciation of the person-in context. What is interesting about the OHSCAP is its departure from an 'audit' approach to assessment, instead the approach is dynamic and interactive. Questions are asked in such a way as to enable the older prisoner *time* and *opportunity* to fully talk about the issues they face. Following this discussion, a care plan is drawn up, detailing any referrals and specific arrangements to be made.

Earlier reference was made of the challenges of identifying prisoners with learning disabilities ('Missing Masses'). The *Hayes Ability Screening Index* (HASI) is a brief, individually administered *screening index* (not diagnostic instrument) of intellectual abilities and because of its specificity to 'screen' maybe viewed as a limited assessment. It was developed primarily to provide a short and effective instrument to indicate the possible presence of learning (intellectual) disability amongst prisoners to determine prisoners who needed a further full-scale diagnostic assessment and to identify possible vulnerabilities of the prisoner. HASI is not a standalone instrument and needs to be viewed as part of a continuum of assessment regimes. HASI is widely used in Australia and in the UK, USA, Canada, Norway and The Netherlands. The Learning Disability Service established

at HM Prison Greenock used HASI (Hayes, 2000) as it was easy and quick to use by non-learning disability professionals and enabled the establishment of a multi-disciplinary team, care plan with achievable outcomes. A follow up study indicated that its use led to positive outcomes, including reduced reoffending (Docherty, 2010).

The *Do-IT Profiler* is a screening tool, used in Scottish prisons, for assessing and planning support for prisoners with learning difficulties and learning disabilities. The *Do-IT Profiler* assesses across five domains; cognitive impairment, social communication, co-ordination, attention deficit and literacy/numeracy, delivering an accessible person-centred approach to supporting people moving through the Criminal Justice System.²⁷ The profiler has been piloted in prisons in the Forth Valley area and NHS Greater Glasgow and Clyde have agreed to work with SPS to roll it out for use in all Scottish prisons. The Do-IT Profiler involves SPS working inter-professionally with health and education, it should be noted that social work are not currently involved in this screening (**Recommendation 8 and 9**).

The SPS *Snapshot Report* (SPS, 2017b, 10) points to some of the difficulties and dilemmas in ascertaining the self-reported needs of prisoners' social care needs. The report observes that some prisoners being surveyed may have *underestimated* or *exaggerated* their difficulties and the report moves to cite three studies that provide a strong case for their estimation that between 8% and 40% in the general population exaggerate medical conditions. Whilst exaggeration does exist, alternative research suggests that this perspective is another form of blaming the victim, instead of viewing a disabled person's actions as a *strategy* to obtain the support/services they require to achieve a better quality of life. These aspects are complex and highlight that when prisoners bargain for services, they do so from a place of overall powerlessness and as such the idea of 'truth-telling' is a vexed question and could be regarded as a tactical decision. We have noted there are alternative explanations as to why some disabled people might 'exaggerate' disability and we would encourage further research explorations in this area (**Recommendation 2, 3**). This portrayal, however, risks characterising disabled people as shirkers, entrenching ideas that people should be grateful for social care or benefits rather than social support being seen as a right (Campbell, 2006; Campbell, 2014). Any social care assessments should proceed on the basis that social care is an entitlement should it be required (**Recommendation 6 and 7**). Careful monitoring and review of social care needs of prisoners by way of a robust assessment process will help to ensure that the balance and mix is correct.

3.7.2 Timing of Assessments?

Walsh et al (2014) argue, that if prisoners are not assessed *on entry* to prison, social care needs are unlikely to be picked up. Nonetheless any assessment of social care needs to understand

²⁷ <https://doitprofiler.com/offenders/>

health and disability and their interactivity with environments are dynamic, permeable and changeable, hence there is a critical imperative for follow up assessments, monitoring and review of social care plan strategies and outcomes. Gaston (2018, 241) calls for assessments for older prisoners to identify early signs of dementia, 'being incarcerated increases the likelihood of not being identified with dementia until the later stages of the disease process, which significantly reduces opportunities for early intervention'. Examples of good practice in assessing older prisoners and those with learning disabilities are also evidencing positive outcomes for staff work satisfaction. In a Welsh prison a secondary screening process was introduced to identify the needs of people with learning disabilities. As a result, care planning, appropriate support packages and outcomes for offenders have improved, along with greater work satisfaction amongst staff (New and James, 2014). In Australia, a computerised assessment tool provides an initial screening process, using a bi-psychosocial approach to assess the needs of people with learning disabilities and provide person-centred guidance for staff (Kirby and Saunders, 2015). Evidence of such practice is limited, the reality in most prisons is they lack any means of identifying people with learning disabilities (Edgar and Rickford, 2009).

3.7.3 Composition of Professional Assessment Teams? (Recommendation 9)

The policy shift towards integration of health and social care in Scotland presents *new opportunities* to develop collaborative inter-professional teams and move away from the domination of medical models of social care assessment principally conducted by medical or nursing personnel. Whilst health management and social care orbit each other they also have different dimensions and preoccupations, for that reason a multidisciplinary approach is critical. However social work needs to play a lead role in social care planning and assessment given their broad remit of person-centred practice, consolidation of capacity building skills for vulnerable people and Throughcare linkages with local authorities. New staff models will have implications for the types of positions engaged by SPS and external providers as well as staff roles and responsibilities (**Recommendation 1, 5, 8 and 9**).

The Care Act 2014 in England states that assessments should be undertaken by social workers, but this is complicated by prisoners not necessarily being imprisoned in their local authority. Prison officers, who lack the skills and knowledge, are often left completing assessments in England, which connects with less than 7% of prisoners with social care needs having a dedicated social worker (Tucker, et al., 2017). Tucker et al. (2017) report that most local authorities had processes in place to assess social care needs on entry, including reception interviews and health assessments, although they weren't identifying *all* care needs/disability. There was evidence of co-producing outcomes, 'care plans were typically being formulated in conjunction with prisoners and other key players' (Tucker, et al., 2017, 10). Under the OHSCAP assessment process, *prison officers* play a lead role (the Older Prisoner Lead) and require significant training. The NICE guidelines refer to a health care professional (suggesting a registered nurse) undertaking the first

and second stage assessments and bringing in other multi-disciplinary team members for pre-release assessments (Bradshaw et al, 2017, 3-4) (**Recommendation 5, 8, 9 and 10**).

3.8 Training (Recommendation 3)

... many prison staff said that they do not have adequate training or tools to identify prisoners with disabilities and support them. As a result, staff were unable to provide reasonable accommodation for people with disabilities, who often lacked appropriate support and can face inordinate delays accessing specialized services. This indicates that the training is inadequate and not preparing the staff effectively for the challenges of the job.

(Human Rights Watch, 2018, 66-67).

Currently training practices around social care for Prison Officers and other staff are mixed and patchy across the prison system in Scotland, UK and internationally. There is little dynamic disability awareness training beyond a focus on functional issues like correct lifting practices (**Recommendation 2**). Disabled prisoners themselves have limited opportunities to engage in group sessions around living with disability and enablement. The literature on the training associated with offering social care in prisons falls into *four* main types:

1. Training for prison staff around different needs, disability, gender etc within the context of *intersectionality*, to improve prison services generally and more specifically in relation to health and social care. The Council of Europe (2018, §7.10) recommends disability training for staff including awareness of multiple and intersectional discrimination (Docherty, 2010; Handtke et al, 2014) (**Recommendation 13 and 14**).
2. Carer-prisoners to develop skills in providing social care (O'Hara, et al., 2015, Stewart and Edmund, 2017) (**Recommendation 12**).
3. Disabled prisoners, to develop disability self-awareness and confidence to promote greater participation in their ICM's and self-determination more generally (**Recommendation 2**).
4. Social workers/external agencies to build knowledge of working in a prison environment (Tucker, et al., 2017). Ironside (2015, 76) suggests joint training for staff and peer carers to develop a co-production care environment (**Recommendation 8 and 9**).

3.9 Systematic Review

It is pleasing to note that our review and subsequent distillation of findings are *confirmed* in the recently published systematic review of two quantitative studies and 5 qualitative studies (n = 7) of *large scale* research projects, drawn from the United Kingdom, Australia and United States

(Stevens *et al*, 2018) examining roughly 500 *older* prisoners.²⁸ The Stevens *et al* (2018) review focused on *older* people, however, there is a *convergence of themes* from their systematic review which coincide with this study. The key themes from the systematic review cover:

- Addressing older persons’ needs: health & wellbeing; loneliness and isolation; anxiety and avoidance.
- Identifying barriers for older prisoners & staff: prison-staff-older prisoner relationships; prison physical environment; budget restrictions.
- Facilitating Engagement with Older Prisoners: older prisoner agency; creativity in older prisoners; peer support among older prisoners.
- Effective Programme Delivery: personnel involved in programmes; legitimacy of programmes.

The Stevens *et al* (2018) systemic review supports the findings presented in this report from a small Scottish study. It aligns our findings with comparable contemporary prisoner experiences of social care and our directions for the future development of social care in Scottish prisons.

3.10 Recommendations: Literature Review

Table 8

Theme	No.	Focus
Knowledge and Understanding	1	Defining social care
	2	Understanding disability
	3	Learning and training
Legal Frameworks	4	Framework for responsibility and resource
	5	Transition between: community-prison-community
	6	Rights based approach
	7	Equality duties and reasonable adjustment
Delivering Social Care	8	Role of social work
	9	Integrated working
	10	Outcomes approach
	11	Holistic assessment
	12	Peer carers
Working with Diversity	13	Cultural change
	14	Data and diversity
	15	Purposeful activity
Wellbeing and Quality of Life	16	Wellbeing and offending

²⁸ We signal caution here about assuming older prisoner needs are similar to ‘younger’ disabled prisoner issues – there maybe crossovers and differences.

4. Findings

Chapter Four brings together the findings of interviews with disabled prisoners and prison governors at three Scottish prisons and online survey responses from the *Integration Joint Boards* (IJBs). In our analysis of the data we have drawn out thematic patterns, but also discontinuities in viewpoints and experiences without necessarily harmonising what might seem as contradictory accounts. The Scottish prison system is diverse in its responses to social care and so are the lives and professional experiences of the participants.

The chapter adopts the following format, we first explore the remit of social care, before moving on to explore the *procedural dimensions* and *socio-cultural dimensions*. The *procedural dimensions* address some of the practical aspects of developing social care in prisons and are drawn from specific questions on these topics in our data collection. The *socio-cultural dimensions* of prison based disability experiences have emerged from the data analysis, supported by the literature review as a paramount aspect of empowering social care, and are situated in prison as a prisoner's 'home'.

The following discussion provides an insight into both current experiences and future aspirations for social care in prisons.

4.1 Remit of Social Care (Recommendation 1)

Defining social care is central to progressing its provision in prisons. There is much work to be done on clarifying definitions of social care at a policy, practice and experiential level, including how social care and support can lead to positive impacts on wellbeing and sense of self. This study through the literature review has already made inroads into producing an *elastic and expansive* definition of social care by recommending the adoption of the *Dilnot Commission's* approach (Commission on Funding of Care and Support, 2011) and our Six Principles of Social Care (Table 6).

Our study findings uncovered a variety of understandings of the remit and definitions of social care (generally, as well as within the context of prisons), with many responses being fragmented, unclear and inconsistent, or simply unknown.

There is no SPS definition [of social care]. (Governor: 3)

There has been no work undertaken around this [social care] definition. (IJB: 10)

No clear definition [of social care] but we think of it as something that supports daily living of prisoners. (Governor: 2)

As conversations shifted away from specifically defining social care, there was a tendency to narrow the configuration of social care to physical access, personal care or functional activities of daily living (ADL), conflating social care with health care and the framing disability within a medical model.

The physical environment of the current prison estate is the biggest barrier to delivering social care (they are not designed for that specific purpose). When commissioning and building future prisons; as well as being accessible, there needs to be additional capacity for adapted cells. (Governor: 4)

The responses from the IJBs on defining social care aligned with prevailing social care policy referring to outcomes and capacity building. The prisoners and prison governors offered broad and holistic definitions, emphasising wellbeing and the social dimensions of social care. Although the response of prisoners, when asked about social care was somewhat uncertain, what became clear is that their vision of social care related to connectivity with 'home' (prison), family, community and future aspirations.

Holistic Social Care

Social care is the communication with the outside world: your family, friends. I have no social life here. (Prisoner: 4)

The concept of 'living in prison' is important as life is no longer put on hold while in prison, we need to think of a 'life in prison' and how this links to the community... Social Care is not just about old age and the infirm or physical disability, it is much broader. (Governor: 3)

Person centred services that are outcome focused building on individual strengths and community assets ... and maintaining independence. (IJB: 3)

'Living in prison' and conceiving of prison as 'home', are simple yet powerful words that could be catalysts for developing a new dialogue around social care that recognises and addresses the diverse needs of prisoners. Diversity and the lack of professionally assessed social care lead to a denial of citizen rights. As one of the prison governors noted 'Prisoners are living in our

communities and should be given the same respect and dignity when in need as other members of our community.’ Deprivation of liberty should not contribute to the deprivation of other rights as a citizen **(Recommendation 5, 6 and 7)**.

Despite numerous shifts in Scottish government policies around the integration of health and social care, self-directed support and a new landscape of social investment in health and wellbeing in the community, when asked to define and discuss social care within the prison context there was uncertainty from both prison governors and the IJBs. There was a sense of disconnect with policy directions and how those directions might impact on current and future arrangements. Throughout the data of particular concern was that 73% of IJB respondents indicated that there was not a legal barrier to implementing social care in prisons, or that, they ‘Do not have enough knowledge to comment’. This suggests there is a lack of clarity around the remit of the current health and social care legal framework for delivering social care in prisons **(Recommendation 4)**.

There was, almost a *sense of waiting* for something, someone to act, to assign demarcations and provide guidance around social care conceptualisation and delivery. There has been some creative work in this area but that work has been driven by *committed individuals* and not necessarily by policy directives. This reveals a lack of organisational awareness, arrested planning processes and the need to promote specific responsibility and leadership to deliver social care in prisons. A clear message from this study is that social care in prisons lacks prioritisation and imagination and runs the risk of being seen as a discreet add-on to existing arrangements.

4.2 Procedural Dimensions

4.2.1 Responsibility

As work progresses to define social care **(Recommendation 1)**, we suggest that this is closely aligned with a *socio-cultural approach to disability* (CRPD) and is viewed as a mechanism of equality and reablement and not simply as a narrowly configured health need **(Recommendation 2)**. The uncertainty and ambiguity surrounding defining social care and applying current policy in practice is reflected in a lack of clarity over who is responsible for delivering social care. Within a community setting, responsibility for social care lies with IJBs and local authorities, with social work as the lead profession. Whilst prison based criminal justice social workers, undertake work in prisons mainly, around assessing risk of future offending, of concern and evident throughout our data was the absence of adult care social work within the prison environment. When there was a reference to adult care social work it tended to refer to its absence or the lack of engagement in meeting the social care needs of prisoners.

That's my big complaint. I've been unable to get support from social workers. (Prisoner: 1)

Some of them [social workers] have been here years and are no good. (Prisoner: 7)

In the absence of formalised social care and a clear adult care social work presence, responsibility for social care is lying with prison officers, the NHS and peer (prisoner) carers. There were mixed views in relation to each of these within our data. Many of the prisoners suggested that prison officers should not carry out any kind of social care support, arguing that it isn't part of their job, '... they get paid to be prison officers not to do healthcare duty' (Prisoner 5). There was also a sense that the prison officers did not see responsibility for social care residing with them, rather their role was seen as focused on custody and security. As a key role in the future delivery of integrated health and social care in prisons, it will be important to consider the future nature of training and support (**Recommendation 9**). Access to care at night time and after 5pm at weekends is particularly challenging to organise and exposes some of the existing *unmet needs* in the prison system.²⁹ Certainly, the lack of 24/7 care makes access to secure and comfortable living difficult.

I don't even try bothering them [the prison officers] at night time. They don't like it, they don't like it. (Prisoner: 3)

The prison governors presented a very compassionate approach to supporting prisoners' needs, 'we should treat all prisoners as human beings who may be struggling – we need to be able to care for them' (Governor 1). Sometimes, this compassion was extended to coming in at night, 'I came into the prison overnight to support staff to care for a prisoner with specific needs that we struggled to identify support for' (Governor 2). Such a scenario is neither sustainable nor satisfactory (**Recommendation 8, 9 and 13**).

Amongst the prison governors the provision of social care was viewed as the responsibility of the NHS and local authorities. There was agreement that each prison should have the flexibility to be able to deploy resources. However as one prison governor put it, there 'needs to be a national dialogue about funding for social care in prison - we also need to consider community provision' (Governor 3) (**Recommendation 4, 5 and 17**). Continuing along similar lines, another prison governor concludes:

²⁹ 'Unmet need refers to identifiable health [or social care] challenges, for which there is a recognised effective intervention' (Mackie & Thorpe, 2014: 10).

In the past the IJB was distant and didn't engage with prisons but this is starting to change. There is an anomaly in that health is 'owned' by the IJB's but prisons are responsible for paying for the social care needs of prisoners. (Governor: 2)

Prison governors also understood that the third sector and local authorities have a responsibility for prisoners while in prison and to prepare them for returning to their community at the end of their sentence (**Recommendation 5, 8 and 9**). In their view more often, it is the prison officer (not the prison based criminal justice social worker) who will refer the prisoner to services, this usually takes place at supportive care meetings where a multi-disciplinary review of prisoner needs are discussed, planned and reviewed fortnightly. Indeed, the prison governors emphasised the role of prison staff providing care that the community will not provide in prison. Prison Officers have provided social care where situations have not been able to be resolved otherwise, but this is not considered part of the prison officer's role and has been provided by caring individuals rather than as part of a standard service.

The IJB's held a variety of views on the matter of responsibility, from being concerned with perceived risks for social care staff working in prisons to the requirements for particularised training. They point to confusion about roles and responsibilities and show that the responsibility for social care in prisons is not something that the majority of IJBs have fully considered. Both the prison governors and the IJBs acknowledged that this was a new area for them.

Prisoner social care is not at the forefront of the minds [of the IJBs]. (Governor: 2)

We still don't know whose job it is to provide social care. (Governor: 3)

Unsure if IJB are aware of social care issues within prison. (IJB: 5)

The question of social care in prisons was not new to all of the IJBs. Some were progressing developments around integrating social care into prisons; but challenges and uncertainties remained with regard to responsibility:

There is a lack of agreed and clear protocols and practice across Health, Social Work and SPS in terms of fully agreed responsibilities.... [applying] self directed support in line with legislation relating to choice are in place and it is suggested there is discussion on the principles and applicability on non-availability within a custodial setting. Discussion has considered the use of peers/fellow prisoners as support and again it is suggested this is fully discussed in progressing future agreed and safe provision in the prison setting. (IJB: 9)

This study did not allow for following up developments in place through individual IJBs. We recommend that established good practice from across Scotland is shared (**Recommendation 5 and 9**).

The following were key areas in relation to responsibility to emerge from the data:

4.2.1.i. Ownership and Control

- National ownership of health and social care in prisons, with strategic level collaboration. 'there has to be strategic guidance from government as opposed to bland strategic statements' (IJB: 5) (**Recommendation 4**).
- It is necessary to develop common understandings and shared goals of the multi-disciplinary team in the prison setting. This needs to cover who needs to work together, and how, expectations and responsibilities. Prison governors expressed a wish for both Local Authorities and the NHS to begin to work more collaboratively with prison staff and prisoners as partners; understanding and valuing the unique professional/experiential knowledge each brings (**Recommendation 9**).
- In the view of prison governors, it does not matter who controls the budget so long as it is available to address the social care needs of prisoners (**Recommendation 4**).

4.2.1.ii. Risks and Silos

- The IJBs understood the risk of agencies working in silos regarding the provision of health and social care in prisons. The responsibility for social care should be shared. It is necessary to have a collaborative approach to providing care (**Recommendation 9**).
- Multiple factors driving social care needs must be taken into consideration as well as the means by which people with social care needs can transfer back into the community (**Recommendation 5**).
- Improvement to health and social care in prisons is challenging, it involves issues of security (for example, escorting prisoners to appointments) which has implications on the way prison systems operate and interact with other services (**Recommendation 13**).

4.2.1.iii. Prison as 'Home' and Staff Flexibility

- Social care should wherever possible deliver the same outcomes in the provision of health and social care services in prison as in local communities. Indeed, prison is 'home' to prisoners and should be conceived of as such by all stakeholders. People in prison must be treated with decency and respect if their social care needs are to be met (**Recommendation 5 and 6**).
- Workforce training and recruitment will need to address and accommodate the evolving roles of everyone in the multi-disciplinary team (**Recommendation 3 and 9**).

4.2.1.iv. Peer Caring and Community

- The role of peer support should be acknowledged. Prison governors say that they 'couldn't do the job' without prisoners who assist other prisoners (Governor 3), although it was noted that many prisoners felt uncomfortable asking for help. Governor 1 highlighted the potential for exploitation, and benefits of peer caring for both the prisoner giving and the prisoner receiving care, 'there is a lot of wasted potential in prison' (**Recommendation 12 and 15**).
- There should be wider discussion about using community alternatives options particularly for people with high level care needs. This would include using community disposals including, for example, a residential requirement to minimise risk (**Recommendation 17**).

4.2.2 Assessment (Recommendation 11)

Assessment is central to meeting the social care needs of prisoners, and it appears sporadic in prisons. Nor is the current practice of Throughcare facilitating for prisoners' social care needs to be met.

They should be asking, when you move in, "What do you need in here?" That would really help. ... You get sick of asking, that's why I'm, emotionally, it's heavy – as I said physically, emotionally, mentally drained. (Prisoner: 5)

Can't remember if I have had a needs assessment. (Prisoner: 2)

'Assessment' was a common response for the IJBs when asked, 'What does your IJB see as the main issues to be addressed in relation to social care in prisons?' Responses related to

transitioning in and out of prison and concerns that most care providers are not equipped to manage risk in addition to care needs. 'Risk' itself remained an unarticulated concept. Change was clearly being called for, and a message emerging from the IJBs was that this needs to be recognised at government level and go beyond 'rhetoric'. Our data suggest that there exists a willingness to work collaboratively to find solutions to achieve a common goal.

To understand social care needs and monitor over time, anticipate need, find creative solutions, [use] co-production and link with third sector providers. (IJB: 11)

Recognising and being able to respond to the changing needs of prisoners must underpin the development of social care assessment within prisons, including the availability for self-referral. Currently prisoners can make a request to see a health professional (Figure 3), there is no equivalent for prisoners to see a professional for support with their social care needs.

Figure 3 - NHS Tayside Prisoner Healthcare Self-Referral Form (reproduction from original)

**NHS TAYSIDE PRISONER HEALTHCARE
SELF-REFERRAL FORM**

Name _____ SPIN No _____

Date of Birth _____ Date _____

Location _____ On Remand Yes / No _____

Liberation Date _____ Court Dates _____
(if known) (if known)

Please advise dates which are not suitable for appointments

I would like an appointment with (please tick):

Nurse Clinic	<input type="checkbox"/>	Nurse Treatment (vaccinations/wound dressing)	<input type="checkbox"/>
GP	<input type="checkbox"/>	BBV	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>	Sexual Health	<input type="checkbox"/>
Optician	<input type="checkbox"/>	Condom Pack	<input type="checkbox"/>

Please note – separate forms are available in the Halls for: Mental Health / Substance Misuse / Podiatry/ Dentist

Reason for appointment:

If you want to ask health care staff a question please write below and we will return a reply:

There was a lack of consistency held by prison governors around how Throughcare assessments can be integrated with existing health assessment and any future social care assessment

process. On that matter, from the perspective of the IJB, a clear pathway of assessment would be helpful in transitional planning. We would suggest, that the initial and ongoing Throughcare assessment and ICM processes be deployed incorporating both health and social care assessments in a simultaneous fashion (**Recommendation 5**).

The IJBs articulated a drive amongst prison governors for change. However, in the view of prison governors themselves, it seems that the *culture of managerialism* within SPS institutional practice is a key barrier to change and leadership. As one stated: 'We have had lots of guidance telling us how to do things but not enough to tell us what the right thing to do is' (Governor 2). Our analysis would suggest that although there is significant good will emanating from SPS, the *absence of a national social care strategy* has induced often reactive, localised responses to social care needs of the prison population, with the resultant effect of a mix of assessment, monitoring and review, a situation very much dependent upon the training and commitments of prison governors. The commissioning of this report is indicative of and an acknowledgement of the need to address these concerns (**Recommendation 4 and 13**).

4.2.3 Education and Training (Recommendation 3)

Integration Joint Board respondents understood that training opportunities can change mind-sets and practices. For the prison governors, training was additionally understood within the context of enhancing the evolving prison officer role which should be aligned with the stated values and vision of SPS (Table 1), and engaging with prisoners at a human level. Throughout the data, the need for an understanding of the unique aspects of prison life and the impact on health and wellbeing were recognised as a prerequisite for all practitioners working with Throughcare. The training of community staff to work within the prison setting was highlighted, and the balancing of the delivery of care and risk.

Prison governors talked of providing training for prison officers to better understand the social care needs of prisoners and to learn from the NHS on providing palliative care. There is crucial learning to be shared from the 2011 transfer of prison health to the NHS, and we believe more relevant learning will emerge as part of the consolidation of a social care strategy in prisons. Considerable work would need to be undertaken with staff at all levels in understanding each other's roles and responsibilities and breaking down any barriers and myths. Greater integrated and collaborative working and learning is required and should be cascaded to create a new culture of delivering health and social care (**Recommendation 9 and 13**).

4.2.4 Throughcare: Continuity of Transitions (Recommendation 5 and 8)

This finding relates to understandings of the ‘prisoner journey’ from the community into prison and back into the community. According to the *Standards in the National Objectives for Social Work Services in the Criminal Justice System: Standards - Throughcare* (Scottish Government, 2004) the term ‘Throughcare’ is used to describe the provision of social work and associated services to prisoners and their families *from the point of sentence or remand*, during the period of imprisonment and following release into the community (s1, emphasis added).

...you have to have something to look forward to getting out, to plan for your release. You know you've got a property to go to, somewhere to live, you've not got to think oh where am I going to stay? If you've got something to look forward to, your mind is set on changing, to getting out. Then you can start thinking about other things. Are there curtains and what not, you can start addressing how to build a life instead of this, falling back into the same thing. (Prisoner: 4)

The *Standards* position social work services in prisons as the ‘critical link between these services’ (s28) especially as there is a significant evidence base that demonstrates that where there are complex health and social needs, transition between services and service settings produces significant barriers for the effective continuity of care (between prisons and into the community) (Mackie & Thorpe, 2014, 5). Despite these *Standards* being in place for 14 years, prisoners spoke of difficulty in accessing social work services when in prison and at all points of the Throughcare journey, including between prisons. Throughcare arrangements, in particular local authorities involvement (requesting advice, guidance and assistance from local authorities) are ‘voluntary’ for prisoners serving sentences of less than four years.³⁰ In practice, Throughcare support is focussed on the statutory supervision of around 5% of people leaving prison on various types of licences/orders. Whilst the *Standards* recognise the need and value of voluntary Throughcare, the fact that people in prison need to a) recognise they may need support, b) believe that support might be available and c) then request a service by self-referring means that very few people leave prison with the support of voluntary Throughcare. Social workers have the skills and knowledge to support prisoners and to assess risk. However, of concern is that the contribution of social work was only minimally noted in any of our data (**Recommendation 8**).

Disabled prisoners encountered specific difficulties in their transition into prison. Disabled prisoners reported essential equipment being lost or not repaired. The lack of availability of equipment and overall support did not correspond to what had been experienced in the community. There is also evidence of significant differences between the resources and support at different prisons, and confusion regarding what prisoners might be entitled to in the community,

an issue that was acutely experienced by those who had been in prison for a lengthy period of time and could compare their experiences. A key message was that prison based social work was not considered to be an acceptable substitute for community based social workers. In relation to preparing for release, the prisoner narratives highlighted that there was little or no support to assist with release planning (**Recommendation 5 and 8**).

You just get let out. When I get out where am supposed to go? You get out with no money, no nothing, one week's money, what are you going to do? You're going to go back to what you know. You're going to offend. (Prisoner: 4)

Is that not crazy, if someone is disabled they should be helping them get back into the community rather than just kicking them out the door with a wheelchair? (Prisoner: 5)

What's troubling me is, and I can't talk about it, come October I will be 65 and I don't know the situation with PIPs (Personal Independence Payment) when you become an aged person. (Prisoner: 6)

Prison governors were unanimous in their desire to see prisoners receive the same level of care in prison as in the community and claimed the intention is for prisoners to remain as independent as possible. However, it is clear that more work is required in achieving this aspiration, starting with greater clarity around who is responsible for supporting prisoners in their transition into and out of prison and greater 'joined-up' thinking and working. The issues for remand, short-term and longer term prisoners also need to be considered as each category presents different issues in relation to their management entering in, within, and moving out of the prison estate. There are also particular issues for offenders who have committed sexual crimes. In all instances, consideration has to be given to the safety of the service providers and the dignity of the prisoner. The challenge of providing health and social care to those who present with the twin concerns of vulnerability and risk requires careful consideration.

We need to think carefully about transfer into the prison and back out again and understand who is responsible for this. ... We need to have better community support for prisoners. Community services have a responsibility for prisoners while in prison and to help prepare them for returning to the community. (Governor: 1)

The data from the IJBs also recognises the challenges in relation to managing the transition from and to the community. The benefits of community access and maintaining professional relationships with professionals in the community was seen as desirable, but no evidence came forward regarding *how* this might be achieved. A particularly challenging group of prisoners in relation to community planning and Throughcare were those who were in and out of custody on a regular basis.

While there appears to be no coherent approach to prisoner transition at this stage, the IJBs highlighted useful starting points for discussion. There appears to be greater clarity in relation to interprofessional working for prisoners who leave prison subject to statutory licence conditions. These prisoners are clearly recognised as the responsibility of the local authority in relation to their on-going Throughcare management. A similar pathway needs to be considered for the transition into prison and for those who leave prison at their sentence end date.

The main issues are the continuity of the needs of the prisoner being met from community to custody and back again. This requires an interface with universal services for example housing providers, employability support, welfare rights on preparation for release. In terms of prisoners subject to licence conditions there is a process in place for their allocated worker to act as the link between services and provide such continuity. For the short term prisoner who has no allocated case worker, this can be a different experience and they find access to services difficult on release. (IJB: 6)

Throughcare assessment provides the opportunity to *identify* and *negotiate* access to services and should be connected up and consolidated with additional health care assessments, and proposed social care and reasonable adjustment assessments, so that a continuous assessment process from sentencing to the date of liberty is comprehensive and streamlined.

4.2.5 Purposeful Activities: Confinement within Confinement (Recommendation 15)

'If prisoners are not engaged in such [purposeful] activity, they are most likely locked in their cells and this I deem not to be purposeful activity.' (HM Chief Inspector of Prisons for Scotland, 2011, *Annual Report 2010-11*, 61).

Under the *Prisons & Young Offenders Institutions (Scotland) Rules 2011*, Part 9 Rule 82/83 there is an expectation, unless excused on health grounds, for *all* prisoners to undertake work, education or counselling for up to forty hours week.³¹ It is important not to conflate health grounds, with disability or inability, with capabilities for purposeful activities. Additionally Rule 84 (*Prisons & Young Offenders Institutions (Scotland) Rules 2011*, Part 9) indicates the necessity of purposeful activities, as reasonably practicable. A *broader remit of social care* should be adopted to facilitate *proactive* purposeful activities for disabled prisoners to promote mental health wellbeing and for it to be incorporated as a key element of a *reasonable adjustment* assessment. Rule 81 (*Prisons & Young Offenders Institutions (Scotland) Rules 2011*, Part 9) in particular,

³¹ Rule 80 and 85 indicates that these expectations about purposeful activities does not apply to people who are untried (e.g. on remand).

requires a report to the prison governor about a prisoner's needs and wishes concerning work and education so as to improve the prisoner's prospects of resettlement into the community. An active approach on the part of social work is vital as many disabled prisoners may not be aware of the possibilities for work and employment training as a disabled employee after liberty from prison. A holistic understanding of social care planning needs firm integration with disabled prisoner's post prison employment opportunities (and corresponding Scottish Government disability employment and education policies) (**Recommendation 1, 2, 5, 6, 7 and 15**).

An enduring theme of the interviews was the absence of mechanisms and forums to explore the *psycho-social implications* of prisoners' disability experience in distinction from medical management requirements. In particular there was a sense of *confinement within confinement*, a case of double jeopardy where disabled prisoners do not have equitable access to freedom of movement, are confined to their cells and restricted to using certain areas of the prison due to access issues and spatial arrangements, thus magnifying their imprisonment experiences.

I'm having to do my full time in closed conditions just because of this [disability], they're setting me up to finish my time here, and I've not got other options 100%'. ... I don't go anywhere I keep myself locked up in here [cell] 23½ hrs a day. (Prisoner: 5)

I have been in here now a year since the work was taken away from us. You're locked up most of the time, if you're not at work you are locked up from 8.30, are opened up at 12.30 for lunch, then again you are locked up. (Prisoner: 6)

Variable (non)access at certain prison estates has also contributed to a sense of disability confinement. The 2013 *Justice Committee, 5th Report, Session 4* (74) identified accessibility to hall-based gyms and outside space as a significant issue and so do the prisoner interviewees: 'I can't access the gym' (Prisoner: 7).

There's quite a lot of disabled people ... you know, I can walk ... walk back and forward by myself. That sort of thing. But I can't walk to the health centre. It's too far for me ... (Prisoner: 1)

They don't expect me to participate in work activities. (Prisoner 6)

Common interview themes included difficulties around asking for assistance and staff awareness about the frustrations induced by the social organisation of prison life such as 'purposeful activities', i.e. access to comparable work programmes and recreation activities akin to other mainstream prisoners. There appeared to be an assumption amongst some prison officers that disabled prisoners are not required to participate, or that prisoners are choosing not to participate

when the narratives from the prisoners indicate that psycho-social and/or physical access factors are preventing them exercising choice. The result is that prisoners can be socially isolated and lonely.

The development of purposeful activities for disabled prisoners, their monitoring and review needs to be linked to ICM and reasonable adjustment planning regimes (**Recommendation 15**). The interviewees suggested a *differentiated approach* to work opportunities was needed that would lead to *reduced access* to purposeful activities:

Prisoner: I've been asking for a cleaner's wing job [passman] and they say well you've got to come out of that [disabled/accessible] cell coz a passman cell has to have two men in it. So I can't go into one of those cells because I need the facilities [accessible cell, including en-suite shower], so am I disabled or am I not? So I'm being discriminated against. If I can't get a cleaners job whilst I'm in that cell, that's being discriminatory because I'm disabled. (Prisoner: 4)

Up until two years ago the activities they had a tea packing section. You made them up for other jails. Great and you got another £2 in your wages. It was £9 week we were getting. Then they reduced our wages to the Disabled Rate which was £7. I was doing that from the second week I was in here and it just stopped. (Prisoner: 6)

4.3 Socio-Cultural Dimensions

4.3.1 Disabled Identity (Recommendation 2 and 13)

Becoming a disabled person can involve a significant upheaval to a person's existing identity and worldview, in particular beliefs about worthwhileness, self-determination and gender identities (expressions of masculinities and femininities). Transition to disability is not a one-off experience, but involves lifelong negotiations with value systems, services and negative attitudes towards disability which can shape the wellbeing of prisoners. Some prisoners, a minority in our study, had *prior experiences* of living with disability and the use of social care in the community and were advantaged to some extent in dealing with the effects of their disability in prison life. The other interviewees *acquired their disability* or health condition whilst being incarcerated in prison, and hence were *unequipped* to process their changed bodies, their support needs and the attitudes of other prisoners. Significantly, all of the prisoners reported that their overall health and/or disability had deteriorated whilst in prison.

I find it hard to take in being disabled, confidence and all that I find that emotionally and mentally hard. ... I'm banged up here 24/7 I'm not wanting to be around people, I've got the walking stick but I'll only use it inside here [in cell], it kills me you know what I mean. I just like having my door locked and I dunna like people coming in and being round people making out everything is alright. It's like people will say I'll get that, I'll do that, and I canna be doing with it, it's just too much too soon.... I've got pride and all that. (Prisoner: 5)

Try to keep myself busy, but cannot do too much [feels exhausted]. (Prisoner: 2)

I was always independent when I first came in. I used to keep my own room clean. Now I've broken things, dropped things. (Prisoner: 7)

Dealing with fatigue, frustrations and the psycho-social dimensions of their disability was threaded throughout the interviews with the prisoners. Fragmented access to holistic pain management programmes (including non-drug alternatives) contributed to their loss of self-worth, docility and depression.

I've got a parole date next year, so come that time I have only 14 months to do. I just want to get out and back on my medication to get some sort of quality of life. [Unable to access appropriate medication]. (Prisoner: 6)

In the narratives of the prisoners there were sometimes explicit or implicit references to the prisoners struggling with accepting that they needed support leading to a reluctance to ask or having tried asking, an acceptance that professional support was not forthcoming 'staff don't do anything'. There was a lot of combative language used, constantly needing to 'fight' as a disabled person to try to access support.

I wouldn't ask for help from other prisoners. ... Staff don't feel this is their job. Some people will stand back and do nothing. (Prisoner: 2)

I pushed to see them [doctors] ... they can't be bothered seeing people like me. (Prisoner: 7)

My health is unbearable. No don't get any support. (Prisoner: 8)

The lack of professional support to enable the prisoners to lead a full life in prison left them dependent on fellow prisoners, creating new tensions, complications and challenges. The predominant message from the prisoners was that they don't feel comfortable asking for help from their peers (**Recommendation 12**). The complexity of intersectional identities, and aligning a disabled identity alongside being male, a criminal and being incarcerated must be visible in the

working practices of prisons. A socio-cultural model of disability needs to be shaping working relationships with prisoners to move away from seeing disability as problematic and a barrier, to participation in prison life, to the environment and social dimensions being the problem, but also the facilitator to change (**Recommendation 2, 3 and 13**).

4.3.2 Power, Communication, Voice and Relationships

Current social care policy, within a community context, is framed around *personalisation* and the use of *outcomes-based* approaches. The SPS vision aligns with this policy discourse, to 'develop a person-centred, asset-based approach'. These approaches are grounded and rely on trust, a rebalancing of power relations and effective communication. The prison governors' narratives highlighted the importance of relationships, listening to prisoners and the 'need to get to know the prisoner as a person'. The prison governors were able to provide examples of high-quality social care with an emphasis on the relationship between the officer and the prisoner, particularly in relation to palliative care. However, experience of person-centred, relational care was limited in the prisoners' narratives. Where positive relationships occurred they were associated with 'good luck', 'favours' and situational circumstances.

Issues of trust and power are relevant to help identify how communication operates and is experienced between prisoners and between prisoners and prison staff. Our findings point to prisoners often feeling disempowered when communicating with prison officers and developing strategies to 'negotiate' their claims. In the absence of formalised social care this was actualised as a conversion of rights into favours and prisoners having to negotiate support from prison officers and/or peers. The prisoners did not feel comfortable asking for help from their peers (see 4.3.1). However, when it happens it is in general based on trust and friendship. This seems to be the same in relation to staff who, in the view of some prisoners, show more empathy. In fact, as suggested by one of the prisoners, you need to treat prison staff well, otherwise you will not have the same level of support. Once again, the issue of right/favour conversion takes place. As a Canadian disability activist remarked, 'goodwill is no substitute for freedom' (Snow, 1996, 80). The prisoner-prison officer relationship seems to be key to understanding the dynamics of accessing rights through the lens of favours. This, however, can overlook that prisoners' behaviour may be impacted by mental wellbeing issues, which tends to put those who are most vulnerable in an even more fragile position within power relations. The inability to 'negotiate' or 'play the rules of the game' can jeopardize access to basic needs on the basis of having 'good relations', which is in itself very sensitive and experiential. As relations of trust are built upon empathetic engagement, it becomes increasingly difficult for prisoners to negotiate their needs, possibly triggering a cycle of negative behaviour, response and outcomes. Formalised social care will help to alleviate and preclude these scenarios (**Recommendation 4 and 16**).

That's when they start oh, oh, and start jumping in. (Prisoner: 4)

Whilst many prisoners are aware of their right to have personal agency and a voice in addressing their social care needs, this awareness was not being translated in prisoners' experiences. The forms of communication utilised appear to be driven by the individual relationships that the prisoners build up with prison officers, not surprisingly, experiences were variable.

Researcher: Do you have a care plan?

Prisoner: No, haven't been shown it or sat down with it. I may have mental problems but I'm not a stupid person. I'm quite aware of what my rights are, what I'm entitled to and what I'm not getting. That's sometimes why I kick off, I say that's against the law, you're breaking the law. That's when they start oh, oh, jumping in. (Prisoner: 4)

I think it's important if you need help that you get help but in here I don't know about other people but you have to fight the system. I don't know, and I don't want to go back to the desk complaining, because in here they [Prison Officers] couldn't be better, they care. (Prisoner: 1)

They try to make decisions I could make for myself. Basically ... you don't get a lot of opportunity [pauses], your opinion is not asked for very often, put it that way, where it could be asked, it would make a world of difference. What do think about this, what do you think about that? No! You do this, you do that! You'll be there at that time and stay there until that person's saw you, it's very regimented. (Prisoner: 6)

They ask you about things, but not things you want to be asked. (Prisoner: 7).

Outcomes based practice is a key aspect of current social care policy that is achieved through service users and professionals co-producing identified outcomes that have meaning to the service user (**Recommendation 10**). The absence of social workers within the prison setting could be a barrier to this level of collaborative work and could help explain prisoners' experiences of feeling unable to speak out about their needs (**Recommendation 8 and 9**).

Communication with people outside of prison (family, friends and other community members) is essential. For some prisoners this meant creating a conduit and a form of advocacy for the prisoners' voices to be heard and needs acknowledged. This advocacy was manifest in different forms, from family members contacting their local MP, to a member of a local church writing to the health board to push for the prisoners' healthcare needs to be addressed. Whilst contact with people outside of prison is important, it was not available for all the prisoners we interviewed. Some prisoners had no contact with friends, family or community outside of prison and this lack

of contact with life outside of prison was seen as impacting on their overall wellbeing. This is an area that could be changed with the adoption of some innovative approaches to facilitating a social link between inside and outside of prisons (**Recommendation 5 and 16**).

Researcher: Do you have family close by or friends?

Prisoner: No So I'm not getting no visits nor nothing. Especially for me having like mental health problems, the worst thing for me, is to be left to my own thoughts.
(Prisoner: 4)

Researcher: Do you have family close by or friends?

Prisoner: No I just cut it all off ... and this shows in the level of my mental state.
(Prisoner: 5)

More work needs to be undertaken to support staff to better understand how to communicate with prisoners regarding their health and social care needs through building trust between professionals and prisoners. Research by O'Brien (2008), the *Experiences of the criminal justice system by prisoners with learning disabilities and difficulties*, suggests that two-thirds of prisoners have communication difficulties, including expressing themselves and understanding particular words, with more than half stating that they had difficulties making themselves understood. While communication skills are important, it is the culture within the prison and allied health and social care professionals that can value the 'voice' of the prisoner and ensure that it resonates through the system (**Recommendation 1, 2 and 10**).

4.3.3 Prison Culture (Recommendation 13)

A common theme that has emerged throughout the findings is the culture of prisons and the need for change to enact social care for prisoners. This final section focuses on prison culture directly in relation to working with a diverse prison population, the changing nature of the prison officer role and integrated working.

Issues relating to 'culture' came in the main from the IJBs and prison governors who appeared to be sensitive to the issues and tensions within the prison system. Prisoners also commented on prison culture, and talked about how working practices impact upon their sense of agency and wellbeing. Prisoners who made specific reference to the culture of the prisons tended to be those who were serving longer sentences and were able to identify encouraging progress, particularly in relation to bullying, and an improvement in the overall treatment and care of prisoners.

I was a prisoner here in the past, it is much better now because you are looked after here ... in the past you were just a prisoner. (Prisoner: 1)

Prison governors highlighted the view that social care needs to become a political priority, to move beyond the belief that a person's life is 'put on hold' while they are in prison and recognise that a person is 'living in prison' (**Recommendation 13**). This demands a prison culture that considers all lives to be meaningful and worthy of the same supports and resources as other members of society (**Recommendation 6 and 7**). Some of the IJBs noted that to achieve the change that is necessary to provide meaningful social care in prisons, change is required in relation to working with diversity (**Recommendation 13 and 14**).

To achieve the vision - work would need to be completed to address issues in relation to discrimination, stigma and cultures. There is a need to learn and understand different cultural background. (IJB: 3)

There will be a requirement to change the culture of both [SPS and NHS] organisations. (IJB: 6)

Prison governors were most attuned to the *professionalisation* and changing nature of the prison officer role. The prison governors raised several key points in relation to culture, including a move away from managerialism towards a greater emphasis on leadership within SPS. Prison governors also spoke meaningfully about the need for an ethical and compassionate approach to the health and wellbeing of their prisoners. They recognised the skills and values of health and social care professionals and acknowledged that SPS staff would benefit from working alongside them, suggesting joint training in some aspects of the tasks involved (**Recommendation 3**). All prison governors spoke of the need for their staff to be flexible in the work that they do, recognising the complexity and sensitivity of providing health and social care within a prison environment. This represents a shift away from the culture of security driven practice of the past.

We need to shift the expectations that staff have of their role – we need people who can be flexible and who can take the initiative. Some officers come from a care background but traditionally this has not been the case. Staff need to be flexible in their roles, they need to take on professionalisation, officers need to take into account the growing expectations of the caring role. (Governor: 2)

Officer roles are changing. We still need to attend to security but caring is also part of our role. We need staff to be flexible and for us to be able to deploy these staff members as required. Many of our staff provide good care and these are the ones who 'know their prisoner'. (Governor: 3)

Changes to the prison officers' role are being introduced with a caring dimension and flexibility being prioritised. Prisoners, who had years of experience of the prison system acknowledged that prison officers were already more 'caring' than in previous years (and in some cases, decades), and that prisoner-prison officer relationships are now much improved. However, the prisoners presented two main caveats. First, clarity over professional roles was required, as well as maintaining professional boundaries. Second, and connected, was that as they spend so much time with prison officers, a 'caring' prison officer can be misinterpreted and create tensions among prisoners.

You start to let officers do that, and then for example, a female officer, everyone's going start saying, oh something's going with them. She's too close, she's too close. That's why they have their job and the healthcare has their job. They live with us, whereas the healthcare they don't have no keys no nothing so nothing can be said. There's always going to be someone who is jealous, he's getting more than me, and they'll hold it against them. (Prisoner: 5)

The overall message from the prisoners was that they don't think prison officers should be providing social care, but could be more caring. This ambiguity around what is care, points to the lack of clarity over what social care is and how prisoners' social needs can be supported to enhance overall wellbeing (**Recommendation 1 and 11**).

From the prisoners' perspectives, a future vision to achieve better outcomes to address their social care needs coalesced around more effective integrated working (which included their active involvement). The prisoners suggested that both SPS, health and social care staff should spend more time talking and really listening to them. Current inter-professional working between SPS and the NHS was not seen as being effective, leading one prisoner to suggest introducing mediators, to address the tensions between SPS and the NHS, to support integrated working.

There needs to be someone on each landing a mediator between the SPS and NHS so the two of them understand where the boundaries are When you try to get the help they fight against it, you canna have that or do that. The best thing would be a mediator because the person gets trapped between the two and honestly, the two of them are just like that {fist to fist} stalemate. (Prisoner: 5)

There appears to be some cultural differences and expectations between SPS and the IJBs in relation to the nature of the collaborative practices that support health and social care provision within the prison setting. Prison governors reported mixed experiences of inter-professional working. They all spoke of a lack of strategic planning and the need for a more consistent approach to the provision of care. They highlighted that areas of joint working are starting to

happen and that lessons from good practice now needed to be shared. IJB responses recognised the need for joint training of staff to ensure a consistent set of expectations in terms of delivery of service and support (**Recommendation 3**). The IJBs also recognised that current policy and procedures were created in isolation and that shared approaches needed to be worked out. There was limited discussion of the role of social work in relation to culture, however, it was suggested that social work needs to revisit its commitment to early intervention and prevention (**Recommendation 8 and 9**).

There is crucial learning from the transfer of prison health to health boards. Considerable work would need to be done with staff at all levels in understanding each other's roles and responsibilities and breaking down any barriers and myths. If a collaborative model was developed where key agencies all have a responsibility and financial contribution; this level of collaboration could be cascaded to create a new culture of working together. (IJB: 4)

Integrated working is the cornerstone of health and social care integration in the community. Integrated working extends inter-professional working to include service users. This report has highlighted many missing pieces to mirroring this level of integrated health and social care in prisons, in particular, the visible absence of adult care social work, but also the need for greater inter-professional working coupled with prisoners exercising choice and control through co-producing outcomes.

4.4 Recommendations: Findings

Table 9

Theme	No.	Focus
Knowledge and Understanding	1	Defining social care
	2	Understanding disability
	3	Learning and training
Legal Frameworks	4	Framework for responsibility and resource
	5	Transition between: community-prison-community
	6	Rights based approach
	7	Equality duties and reasonable adjustment
Delivering Social Care	8	Role of social work
	9	Integrated working
	10	Outcomes approach
	11	Holistic assessment
	12	Peer carers
Working with Diversity	13	Cultural change
Wellbeing and Quality of Life	15	Purpose activity
	16	Wellbeing and offending
	17	Alternatives to custody

5. Recommendations

Providing formalised and sustainable social care in Scottish prisons will demonstrate a commitment by the Scottish Government to situate the integration of health and social care within both a community and prison environment. Achieving meaningful and impactful social care in an increasingly diverse prison population is complex. Current legal and policy mechanisms provide a foundation for future development; we recommend strategic planning and modelling should focus on the process of service delivery and enhanced understanding around working with diverse populations.

The Recommendations have been introduced throughout the report under themed headings and are detailed fully in Table 11. The Recommendations have been framed within a Human Rights Based Approach (HRBA), socio-cultural understanding of disability and our *Six Principles of Empowering Social Care* (Table 10) which provide the structure for the integration of health and social care in prisons.

Table 10

Six Principles of Empowering Social Care	
1.	Achieving outcomes for a meaningful life should be the driver for social care.
2.	Person centred approaches should be embedded in social care, ensuring service users are listened to and included in co-producing outcomes.
3.	Disability is not just a diagnostic phenomenon, it is highly individualised and evolves over time.
4.	Human wellbeing and individual lives involve complex and changing dimensions, social care needs to be cognisant of service users' inner (psycho-social) and outer (social) worlds.
5.	Integrated working requires understanding and collaboration between professions and service users.
6.	Oppressive, thoughtless and unjust attitudes and practices should be challenged and addressed.

The Recommendations cover 17 key areas that have emerged from the literature review and study findings. The Recommendations are designed to support and guide the implementation of formalised and sustainable social care in Scottish prisons.

The commissioning of this report is indicative of the Scottish Government's ambitions and commitment to transform the practice and experience of social care in Scottish prisons. This is

pioneering, long term work, with complex challenges and no easy solutions. This report evidences an acknowledgement for the need for change and a willingness to work differently to achieve change in the lives of people in prison when, for a period of their lives, 'home' must be re-defined, but must ultimately still remain a home that enables active involvement in a 'local community' and a meaningful life.

5.1 A New Vision for Social Care in Prisons: Recommendations

Table 11

Theme	Focus	Recommendations/Areas for Development/Action
Knowledge and Understanding	1. Defining social care	<p>1.1 We recommend that our <i>Six Principles of Empowering Social Care</i> and the <i>Dilnot Commission's</i> (2011) definition of social care be adopted to frame a broad and holistic approach to defining social care.</p> <p>1.2 Social care in prisons should focus on developments for older prisoners as well as younger disabled prisoners.</p>
	2. Understanding disability	<p>2.1 Policy, service planning and activity programmes should be developed according to global best-practice indicated by the UN <i>Convention of the Rights of Person with Disabilities</i> (2006) which recognises disability as <i>evolving</i> and shaped by interactions with the person in their environment.</p> <p>2.2 A broader understanding of disability, including social and environmental perspectives, should be adopted to reduce the likelihood of disabled people experiencing more challenging conditions and fewer opportunities than their non-disabled peers.</p> <p>2.3 Psycho-social and therapeutic interventions should be introduced to support the transition to and development of an affirming disabled identity run by disabled people or disabled ex-offenders.</p> <p>2.4 Awareness-raising is required for staff and prisoners to develop understanding of disability and working/living with diversity, including the accumulative effects of exclusion.</p>
	3. Learning and training	<p>3.1 Incorporate learning from related developments and research, for example, the 2011 transfer of health from SPS to NHS and Macmillan Palliative Care in Prisons.</p> <p>3.2 Identify ways for sharing best practice and knowledge across all domains of practice, including through research with academic partners and other external</p>

		<p>organisations to evaluate and inform future work and to support the development of a culture of learning and inquiry.</p> <p>3.3 Develop opportunities for joint learning for health, social care and SPS staff on understanding social care, disability, working with diversity and the impact of prison on health and wellbeing.</p>
Legal Frameworks	4. Framework for responsibility and resource	<p>4.1 The responsibility for delivery of social care in prison needs to be explicit. This may include extending or clarifying current legislation on health and social care, <i>Public Bodies (Joint Working) Scotland Act 2014</i>, <i>Social Care (Self-directed Support) (Scotland) Act 2013</i>, the <i>Management of Offenders (Scotland) Bill</i> and the <i>Prison and Young Offenders Institutions (Scotland) Rules</i> to make direct reference to health and social care in prisons.</p> <p>4.2 People in prison should be entitled to the same quality of integrated health and social care that is available in the community. This should be more clearly articulated in policy and legislation.</p> <p>4.3 Resources need to be allocated appropriately to meet the social care needs of people in prison.</p>
	5. Transition between community/prison/ community	<p>5.1 Enact more fully the current Standards around Throughcare, <i>National Objectives for Social Work Services in the Criminal Justice System: Standards – Throughcare</i>.</p> <p>5.2 There is significant scope to improve the information and care provision arriving with people at reception into prison and leaving with them at release.</p> <p>5.3 Continuity in the provision of medication from community to prison is essential for the wellbeing of prisoners.</p> <p>5.4 All case and care management processes should be aligned into a holistic assessment and delivery system whether the issues are around risk/offending or regarding support to improve health and well-being and reasonable adjustment.</p> <p>5.5 Prisoners should be able to contribute meaningfully to plans that seek to support their transition back to the community.</p> <p>5.6 Issues relating to the consistency of health and social care on transitions into, out of and through the prison estate should be addressed including decisions on the nature of 'residency' and the meaning of 'home'.</p>
	6. Rights based approach	6.1 The <i>European Convention on Human Rights 1950</i> and the <i>UN Convention on the Rights of Persons with Disabilities 2006</i> , in tandem with <i>the Equality Act</i>

		<p>2010 (UK), should be used as overarching frameworks guiding the development of social care in prisons.</p> <p>6.2 We recommend framing social care in prisons within a Human Rights Based Approach (HRBA) and the Scottish Human Rights Commission’s PANEL Principles.</p> <p>6.3 Prison itself should be the punishment for crime and that people in prison retain their rights as citizens to health and social care that is equivalent to people in the community.</p>
	7. Equality duties and reasonable adjustment	<p>7.1 Approach social care needs first and foremost as an <i>equality duty</i> that enables disabled prisoners to be on a commensurable footing with other prisoners, and secondly as a mechanism for meeting the health and developmental goals of the disabled prisoner.</p> <p>7.2 Reasonable adjustment should be a core plank of working within an equalities framework, central to social care assessment processes and accessibility in a way that anticipates needs rather than reacts retrospectively, and considers social dimensions as well as the physical environment.</p>
Delivering Social Care	8. Role of social work	<p>8.1 Social work need to be more visible and involved with offenders at each stage of their journey through the criminal justice system: from sentencing, time in prison, through to release.</p> <p>8.2 The commitment of social work to prevention and early intervention work with people in prison should be enhanced.</p> <p>8.3 Local authority responsibility for people who are temporarily living within their jurisdiction, should be re-examined.</p>
	9. Integrated working	<p>9.1 The multi-disciplinary team, its role and composition should be key to the delivery of integrated health and social care in prisons.</p> <p>9.2 We recommend that social work play a lead role in co-ordinating and assessing social care in prisons and that teams have a diversity of professionals involved, including medical or nursing staff, occupational therapists, mental health staff, rehabilitation workers and others.</p> <p>9.3 The role of the prison officer is pivotal in ensuring people in prison are able to access health and social care.</p>
	10. Outcomes approach	<p>10.1 Embed person-centred and outcomes-based approaches in prisons and explore issues around power dynamics and ‘learned helplessness’.</p>

		10.2 Identify ways of empowering prisoners to have personal agency and a voice over issues impacting on them at an individual level, over areas of prison life and supporting contact with family and friends outside of prison.
	11. Holistic assessment	<p>11.1 The means by which people in prison identify their needs and desired outcomes should be through a holistic and multi-disciplinary assessment process.</p> <p>11.2 Assessment timing, nature, tools and referral pathways should be considered and developed.</p> <p>11.3 People in prison need to be able to self-refer for health and social care in a way that will promote outcomes and address inequalities arising through ill-health or disability.</p> <p>11.4 The concept of managing risk in the context of prisoners who are vulnerable in prison and potentially on their return to the community needs to be incorporated into assessment.</p>
	12. Peer carers	<p>12.1 Review the approach to peer carers in light of the judgement that the State cannot shift its duties for care onto other prisoners whilst recognising that for many people in prison, caring for or being cared for by a peer is a positive experience.</p> <p>12.2 Explore issues of care service/carer registration and training.</p> <p>12.3 We recommend introducing group peer mentoring programmes run by disabled people or disabled ex-offenders.</p>
Working with Diversity	13. Cultural change	<p>13.1 There needs to be development in relation to the idea that prison is a place where people live, as “home”, and their lives continue.</p> <p>13.2 Shared ethos, values and principles to underpin cultural change should be explored at all levels in the organisations involved and the notions of “leadership” as a mechanism to drive cultural change.</p> <p>13.3 The current prison regime makes the delivery of health and social care on a 24 hours basis difficult. Aspects of the security rules that stop people getting the care they need should be reviewed and innovative solutions explored.</p> <p>13.4 The process of change must include the ‘voice’ or experience of the prisoner.</p>
	14. Data and diversity	14.1 Consider the need for segmentation (intersectionality) of data about the characteristics and needs of people in prison to allow analysis that recognises the range of people in prison, their individual characteristics so that the needs of complex population groups (protected characteristics) are taken in account in service monitoring and evaluation.
Wellbeing and Quality of Life	15. Purposeful activity	15.1 Social workers and prison officers need to be pro-active in ensuring and supporting access to purposeful activities that reflect individual strengths, interests

		<p>and needs.</p> <p>15.2 Purposeful activities should include developing skills for work and employment on release irrespective of protected characteristics.</p> <p>15.3 Disabled prisoners should have the same access to and payment from involvement in purposeful activities as all prisoners.</p> <p>15.4 Peer caring should be explored as a purposeful activity.</p>
	16. Wellbeing and offending	<p>16.1 Incorporate the evidence that improved access to welfare and services can improve wellbeing and reduce the likelihood of further offending behaviour.</p> <p>16.2 The impact that prison can have on health and wellbeing should be overtly recognised.</p> <p>16.3 Develop understanding of prison as “home” for the people who are living there.</p> <p>16.4 Recognize the value of relationships to be people in prison and develop innovative approaches to support people in prison to maintain external relationships, contact with family and friends outside of prison.</p>
	17. Alternatives to custody	<p>17.1 There should be wider discussion about using community alternatives to prison for people with particularly high level care needs.</p> <p>17.2 Effective multi-disciplinary work is required to introduce community alternatives to prison and to ensure that risk is fully incorporated into care planning and that Courts and the Parole Board are confident in the approaches recommended.</p>

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7. Appendices

Appendix 1: The Nelson Mandela Rules

Appendix 2: The *National Offender Management Service*, '*Prisoners Assisting other Prisoners*'

Appendix 3: Research Ethics Documentation

Appendix 1 - The Nelson Mandela Rules³²

One of the key principles defined by the *Nelson Mandela Rules* (hereafter NMR) is the accounting of individual needs and a focus on reintegration to society. It is assumed that deprivation of liberty should not aggravate the suffering inherent to imprisonment. Therefore, prison should offer education, vocational training and work and other forms of assistance in line with the individual treatment needs of prisoners (Rules 2 and 3). There are some specific recommendations in relation to disabled prisoners that should be observed. The NMR states that prisoners with physical, mental or other disabilities should have *full and effective access* to prison life on an equitable basis (Rule 5). Rules 109 and 110 are specific recommendations to disabled prisoners. It is relevant to quote them as a whole:

B. Prisoners with mental disabilities and/or health conditions

Rule 109

1. Persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.
2. If necessary, other prisoners with mental disabilities and/or health conditions can be observed and treated in specialized facilities under the supervision of qualified health-care professionals.
3. The health-care service shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.

Rule 110

It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric aftercare.

In respect to health-care services (Rules 24 to 35), it is stated that health care should be a State responsibility, and prisoners should enjoy the same standards of health care that are available in the community. Furthermore, health-care services should be organised in close relationship with the public health administration. Some key areas highlighted from the NMR:

- Every prison shall have in place a health-care service tasked with evaluation, promoting, protecting and improving the physical and mental health of prisoners. The health-care team should consist of an interdisciplinary team with the qualification, clinical independence and expertise (Rule 25);
- Medical files should be transferred to health-care service of the receiving institution upon transfer of a prisoner and shall be subjected to medical confidentiality (Rule 26);

Rules 27 and 33 consider the relevance of health-care professional autonomy and authority on decisions made to enhance the health of prisoners. These seem to be critical areas that challenge prison dynamics and decision making around prisoners' management. It is an area that demands further investigation as something that has been pointed out by recent reports on the transfer to NHS in Scotland (for example, Royal College of Nursing, 2016; The Scottish Parliament, 2017).

- 'Clinical decisions may only be taken by the responsible health-care professional and may not be overruled or ignored by non-medical prison staff' (Rule 27);

³² General Assembly resolution UN Doc A/RES/70/175, annex, adopted on 17 December 2015.

'The physician shall report to the prison director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment' (Rule 33);

Interestingly, social care is not identified in the rules as a specific area liable for safeguarding, rather the rules focus on health, in a biomedical sense. There are further recommendations that relate to prisoners' disabilities and its relation to disciplinary sanctions. For example, Rule 39 recommends that 'before imposing disciplinary sanctions, prison administrations shall consider whether and how prisoner's mental illness or developmental disability may have contributed to his or her conduct' and therefore 'prison administrations shall not sanction any conduct of a prisoner that is considered to be the direct result of his or her mental illness or intellectual disability' (Rule 39.3). This is continued in the Rule 45 that recommends that the imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures (Rule 45.2). Similarly, it is recommended that health-care professionals report to the prison director any adverse effect of disciplinary sanctions and advise the director if they consider it necessary to terminate or alter the disciplinary sanctions for physical or mental health reasons (Rule 46.2).

It is recommended that social workers (among other specialist professionals) should be in sufficient number, secured on a permanent basis (Rule 78). Unsurprisingly given the lack of inclusion of social care provision in the rules, there is no reference to the work to be carried out by social workers, but there is some guidance on the work to be done as part of support offered before the completion of the sentence to ensure the prisoner a gradual return to life in society (Rule 87). There is also emphasis on the need to keep prisoners integrated to the community through the work of community agencies that should assist the prison staff in the task of social rehabilitation of the prisoners (Rule 88). It is suggested that services and agencies 'shall be centralised and coordinated to secure the best of their efforts (Rule 108). Social care needs assessment is related to Rule 92, that emphasises the need to identify 'the individual needs of each prisoner, taking account of his or her social and criminal history, physical and mental capabilities and aptitudes, personal temperament, the length of his or her sentence and prospects after release' (Rule 92.1). In addition:

- 'For every prisoner with a sentence of suitable length, the prison director shall receive, as soon as possible after his or her admission, full reports on all the matters referred to in paragraph 1 of this rule [see above]. Such reports shall always include a report by the physician or other qualified health-care professionals on the physical and mental condition of the prisoner' (Rule 92.2).

The NMR also refers to the need to prepare 'a programme of treatment' for prisoners:

- 'As soon as possible after admission and after a study of the personality of each prisoner with a sentence of suitable length, a programme of treatment shall be prepared for him or her in the light of the knowledge obtained about his or her individual needs, capacities and dispositions' (Rule 94).

Appendix 2 - The National Offender Management Service (NOMS), 'Prisoners Assisting other Prisoners'³³

NOMS has established 8 Principles that guide formal assistance by other prisoners:

1. Prisoners assist other prisoners in a range of contexts. *The benefits of engaging in such activities, both as a contribution to the prison community and in supporting rehabilitation, must be explained to prisoners.*
2. *Prisoners must not be relied upon to provide assistance that is the statutory responsibility of another service, for example health or social care services.*
3. There are limits to what it is appropriate for prisoners to do for other prisoners. *Governors must be confident that these are clearly explained to prisoners who provide assistance and, as far as possible, are understood by those receiving assistance. Where the assistance is related to social care the prison's local lead for social care must ensure that the appropriate boundaries are identified and explained in the prisoner's care and support plan. Where a care and support plan is not in place, or is not yet in place, all contributions to a prisoner's social care must be recorded locally.*
4. *All prisoners providing assistance to other prisoners as part of a formal scheme must be appropriately selected, risk assessed, trained, supported and supervised.*
5. Formal arrangements for prisoners to provide assistance to other prisoners may utilise support from prisoners who are paid by the prison as a form of work or prisoners acting as unpaid volunteers. *Prisoners must be made aware of which arrangements apply, and in either case must choose to take on the role and be permitted to withdraw from it on reasonable grounds without adverse impact on other opportunities for work or rehabilitation.*
6. *Prisoners providing assistance to other prisoners and those who are receiving assistance must be made aware of policies which relate to safeguarding, and in particular how to raise concerns if they witness or experience instances of abuse or neglect.*
7. *All formal arrangements for prisoners to provide assistance to other prisoners must be consistent with PSI 30/2013 Incentives and Earned Privileges and encourage prisoners to act in accordance with the behavioural expectations set out within it.*
8. *Arrangements for prisoners to provide assistance to other prisoners may be supported by relevant partner organisations but must always remain primarily the responsibility of the prison (NOMS, 2016, emphasis in original).*

³³ PSI/2015, (2016)

Appendix 3 – Research Ethics Documentation

Participant information sheets and consent forms were developed for the interviews with prisoners and prison governors, and for the Integrated Joint Boards to participate in the online survey. The following documentation are presented below:

- A. Prisoner: Participant Information Sheet (participant details were amended for use with prison officers)
- B. Prisoner: Consent Form (participant details were amended for use with prison officers)
- C. Prisoner: Interview Schedule
- D. Prison Governor: Interview Schedule
- E. Integration Joint Board: Participant Information Sheet
- F. Integration Joint Board: Consent Form
- G. Integration Joint Board: Online Survey Questions

Ethical approval for this study was received from the University of Dundee Ethics Committee and SPS Committee and SPS Research Ethics and Access Committee.

A.

PRISONER PARTICIPANT INFORMATION SHEET INVITATION TO TAKE PART IN A RESEARCH PROJECT ON SOCIAL CARE IN PRISONS

You are invited to take part in a research project looking at the current provision and future planning of health and social care in prisons. We want to ensure prisoners' voices are included and so want to know about your experiences and thoughts on this important topic. Your participation will make a valuable contribution to this project.

We will produce a project report that will inform decision making to develop better provision of social care in Scottish prisons.

The project is led by four researchers from the School of Education and Social Work, University of Dundee: Dr Susan Levy, Dr Lynn Kelly, Dr Fiona Kumari Campbell and Dr Fernando Fernandes. Social Work Scotland have funded the project and it will be overseen by the Scottish Prison Service and the Health and Social Care in Prisons Programme Board.

WHAT TO EXPECT

- The Scottish Prison Service will arrange for you to participate in a one-hour semi-structured interview with one researcher.
- The interview will be audio recorded, if you do not want to be recorded please indicate this on the consent form.
- Your interview will focus on your experiences of and thoughts on social care in prisons.
- The project is addressing social care and so issues around personal care will be covered. The researchers are experienced disability researchers and are fully aware of communication and support strategies around disclosure of disability and concerns related to potential vulnerability.

TERMINATION OF PARTICIPATION

- Participants can withdraw at any time during the interview process without any explanation and without penalty.

CONFIDENTIALITY/ANONYMITY

- At the beginning of your interview the researcher will ensure that you are familiar with the project, the nature of confidentiality, consent and expectations before formally commencing the interview.
- All interviews will be anonymised, no personal/confidential information will be recorded.
- The project will not collect data on criminal behaviour or convictions.
- The data collected will be stored on a secure University of Dundee system that is password protected. Data will be kept for 10 years and then destroyed.
- Other researchers may use the findings from this research in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information.

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

B.



Please tick the appropriate boxes

Taking Part

Yes No

I have read (or have had read out) and understood the Participant Information Sheet

I have been given the opportunity to ask questions about the project

I agree to take part in the project

I agree to my interview being audio-recorded

I understand that my taking part is voluntary; I can withdraw from the project at any time and I do not have to give any reasons for why I no longer want to take part.

I understand that my words may be quoted in publications, reports, web pages, and other research outputs, and that these words will be anonymised and de-identified.

Use of the information I provide beyond this project

I agree for the data I provide to be archived at the School of Education and Social Work, University of Dundee for a period of 10 years.

I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.

Name of participant [printed]

Signature

Date

C.



Social Care in Prisons – Prisoner Interview Questions

1. Context/Profile

1. Can you tell me about your social care needs?
 - a. What does social care mean to you?
2. Did these start before or after coming to prison?

2. Social Care Needs in Prison

1. Have you told a member of staff about your social care needs?
 - a. If yes, who did you tell and when did you first tell them?
 - b. If no, why not?
2. Have you had a formal needs assessment?
 - a. If yes, is there a plan in place to meet any needs you have/are these being met and are you happy with the plan?
 - i. Is there a plan in place to meet your social care needs upon release into the community?
3. Do you think your social care needs have deteriorated since you've been in prison?
4. Do you have access to disability equipment to assist you with daily activities, e.g. braille machine, BSL assistance, light weight wheelchairs, bedding supplies?
5. Are you aware of what rights you may have to care support and reasonable disability accommodations in prison?
6. Do you have a say over how your social care needs are met whilst in prison?
 - a. How important it is for you to have a say in how your social care needs are being met, now and in the future?
7. Who is currently assisting you with your social care needs?

	Yes	No
Social Care Staff?		
NHS Staff?		
Prison Officers?		
Other Prisoners?		
Anyone else?		

8. How important it is for you to have the *same people* (carers or officers) supporting you with your social care needs?

3. Relations with Prison Staff

1. If you receive social care from prisoner officers, do you think this has influenced your relationship with them or how they view you?
2. Do you feel comfortable asking for disability/care help from prison officers?
3. How do you think prison officers view your social care needs?

	Yes	No
People act as if accommodations for my disability/health are unnecessary?		
People don't expect me to participate in a work activity because of my disability/health?		
Because I have a disability people try to make decisions for me that I could make myself?		
People offer me unnecessary help because I have a disability?		
People don't see me as a whole person because of my disability?		

4. Relations with Other Prisoners

1. Do you feel comfortable asking other prisoners for assistance relating to your health condition/disability needs?
2. How did you find bringing up your health conditions/disability needs with other prisoners?
3. How do you feel about prisoners providing care to other prisoners (e.g. pushing wheelchairs)?
4. Are you aware of any systems in place to monitor disagreements or possible abuse from prisoners providing care to other prisoners?
5. Has your health condition/disability affected your relationship with other prisoners?

5. Prison Experiences

1. Do you think your disability/health has impacted on how you spend your time and what you do in prison?
2. Has your disability/health caused you any embarrassment or discomfort when you've been with others in prison?
3. Have you experienced stigma/hostility linked to your disability/health condition?
4. Have you received any special support to help deal with adjusting your disability/care needs to the prison environment?

6. Other comments

D.



Social Care in Prisons – Governor Interview Questions

1. Does SPS have a working definition of social care?
2. What do you see as the main issues to be addressed in relation to providing social care in HMP XXX?
3. What are the key challenges for working with prisoners with social care needs in HMP XXX?
4. What information is available for staff and prisoners in relation to social care in HMP XXX?
5. Can you give examples of good practice of current provision of social care in HMP XXX?
6. Does social care feature in your local annual delivery plan?
7. Who is/should be responsible for providing social care in HMP XXX?
8. Do you think that there are any gaps in existing training for SPS staff in relation to social care?
9. Do officers have opportunities for discussing the caring dimensions of their role?
10. Do you consider 'care' as part of the officer ; prisoner relationship?
11. What are the financial implications of delivering formalised and sustainable social care in HMP XXX?
 - a. Current spend on social care available?
12. What are the organisational barriers and facilitators to providing social care in HMP XXX?
13. What is your vision for the future of social care in prisons (suggestions for model of social care)?
14. Other comments

E.

INVITATION TO TAKE PART IN A RESEARCH PROJECT ON HEALTH AND SOCIAL CARE IN PRISONS

The *Social Care in Prisons* project aims to explore and respond to the absence of formalised and structured social care in Scottish prisons and the corresponding impact on prisoners' lives. An ageing prison population coupled with greater awareness of the social care needs of prisoners irrespective of age, makes this project both timely and very relevant.

We are collecting data in three prisons with prisoners and staff, and through an online survey with all Integrated Joint Boards in Scotland. The survey covers questions on the planning and provision of social care in prisons. The perspectives from your IJB will make a valuable contribution to this project. A project report will inform future decision making and the development of a model of social care for prisons.

The project is led by four researchers from the School of Education and Social Work, University of Dundee: Dr Susan Levy, Dr Lynn Kelly, Dr Fiona Kumari Campbell and Dr Fernando Fernandes. Social Work Scotland are funding the project and it will be overseen by the Scottish Prison Service and the Health and Social Care in Prisons Programme Board.

WHAT AM I REQUIRED TO DO?

To answer the questions in the short online survey.

HOW LONG WILL THE SURVEY TAKE TO COMPLETE?

The survey will take approximately 20 minutes to complete. You can edit your survey (ie go back and change a response as you work through it), but once you submit the survey you will not be able to edit the answers you have given.

WILL MY DATA BE KEPT CONFIDENTIAL?

Yes. You are not asked to provide your name or anything which will directly identify you. The research team abide by statutory data protection requirements. The data will be stored on a secure University of Dundee password protected system, and kept for 10 years before being destroyed. Other researchers may use the findings from this research in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information.

DO I HAVE TO PARTICIPATE?

No. You don't have to participate in this research and you are free to opt out of the research at any time. You can also leave blank any question/s you do not wish to answer.

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

FOR FURTHER INFORMATION ABOUT THIS RESEARCH STUDY

Please contact: Researchers: Dr Susan Levy, University of Dundee, s.levy@dundee.ac.uk, 01382381545 or Dr Fiona Kumari Campbell f.k.campbell@dundee.ac.uk, 01382 381425. |

F.



IJB SURVEY CONSENT FORM: HEALTH AND SOCIAL CARE IN PRISONS PROJECT

Please tick the appropriate boxes

Taking Part

- | | Yes | No |
|---|--------------------------|--------------------------|
| I have read and understood the Participant Information Sheet | <input type="checkbox"/> | <input type="checkbox"/> |
| I have been given the opportunity to ask questions about the project | <input type="checkbox"/> | <input type="checkbox"/> |
| I agree to take part in the project | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that my taking part is voluntary; I can withdraw from the project at any time and I do not have to give any reasons for why I no longer want to take part. | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that my words may be quoted in publications, reports, web pages, and other research outputs, and that these words will be anonymised and de-identified. | <input type="checkbox"/> | <input type="checkbox"/> |

Use of the information I provide beyond this project

- | | | |
|--|--------------------------|--------------------------|
| I agree for the data I provide to be archived at the School of Education and Social Work, University of Dundee for a period of 10 years. | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form. | <input type="checkbox"/> | <input type="checkbox"/> |

Name of participant [printed]

Signature

Date

Project contact details for further information: Researchers: Dr Susan Levy, s.levy@dundee.ac.uk or Dr Fiona Kumari Campbell (f.k.campbell@dundee.ac.uk). |

G.



Survey Questions for Integration Joint Boards

1. How does your Integration Joint Board define social care?
2. What does your Integration Joint Board see as the main issues to be addressed in relation to social care in prisons?
3. What are the key challenges for working with prisoners with social care needs?
4. What provision has your Integration Joint Board made in its commissioning plans for health and social care integration in prisons?
5. Who should be responsible for providing social care in prisons?
6. How should prisoners' social care needs be assessed?
7. Are there workforce development training needs required for delivering social care in prisons?
8. Can you identify any legal barriers to implementing social care in prisons?
9. What are the financial implications for delivering social care in prisons?
10. How do you envisage personalisation and co-production being applied to social care in prisons?
11. Can the National Health and Wellbeing Outcomes be applied to social care in prisons?
12. What are the organisational barriers to providing formalised and sustainable social care in prisons?
13. What are the organisational facilitators to providing formalised and sustainable social care in prisons?
14. What is your vision for the future of social care in prisons?
15. Other comments



School of Education
and Social Work
University of Dundee

