Healthcare in Prisons Consultation Response from Scottish Drugs Forum, Hepatitis Scotland and HIV Scotland

- Scottish Drugs Forum is a membership based drugs policy and information service and is a national resource of expertise on drug issues.
- Hepatitis Scotland is the national voluntary sector organisation, funded by the Scottish Government and hosted within Scottish Drugs Forum, to help improve responses to viral hepatitis prevention, treatment and support.
- HIV Scotland is the national HIV policy organisation for Scotland, working on behalf of all those living with, and at risk of, HIV.

What do you consider are the current pressures on health and social care provision in prisons?

How well do you consider that these pressures have been responded to?

To what extent do you believe that health inequalities are/ could be addressed in the prison healthcare system?

What are the current barriers to using the prison healthcare system/ improve the health outcomes of the prison population?

Can you identify potential improvements to current services?

What do you think the main pressures will be in the next 15 years?

Operational management

It is challenging to deliver person-centred health care within the constraints of a secure environment and the current operating procedures within Scottish prisons. Health staff in prisons spend large amounts of time supervising the dispensing and consumption of medication in prison and this can often amount to the entire workload of prison nurses. This is partly due to the security required to move prisoners around a prison to receive their medication.

Resolution should be made by senior management within prisons and health managers that

- operational issues around staffing and location should be resolved to allow nurses and healthcare staff more time with prisoners to address their health needs rather than spend a high proportion of their time dispensing medication.

Coordinated provision of health care is not solely an NHS responsibility. Prisons management priorities and local policies regarding prisoner health needs must be evidence based and supported across the entire prison estate.
**Drug treatment**

Other pressures are self-imposed including drug treatment regimes that would be regarded as poor practice in community services being adopted as standard within prisons including the refusal of drug treatment and non-optimal prescribing of medication to patients i.e. under-dosing – a potentially dangerous and wasteful practice.

- The new *Drug Misuse and Dependence UK Guidelines on Clinical Management* (The ‘Orange Guidelines’) are appropriate for Scottish prisons and should be adhered to as an model of good practice.

As far as treatment for drug problems is concerned the following principles should guide the development and delivery of treatment in prison settings

- A prison sentence should be viewed as an opportunity for people with drug problems to work with professionals to address their drug and other health issues and they should be encouraged to engage in treatment and accept support and to engage in treatment which can be continued in the community after liberation.

- People in prison should be afforded continuity of care from the community, particularly in relation to opiates replacement therapy. This means that a seamless transition to the same treatment in prison as in the community should be achieved.

Non-fatal overdose is a key indicator of later mortality and the most powerful predictor of non-fatal overdose appears to be past experience of overdose. Among those who had been incarcerated recently, the risk of overdose was almost four times greater for those who had also overdosed in the past. This finding and other literature suggests that previous overdose experience does not increase the perception of risk for subsequent overdose but rather increases risk. Kinner and colleagues’ finding that drug injection in prison was a risk factor for overdose on release is at odds with the view that reduced drug tolerance is the overriding risk factor. Non-fatal overdose may therefore be a key marker for an individual having significant risk behaviours and therefore at greater risk of fatal overdose.

Engaging and retaining people in high quality treatment that meets good practice guidelines should be the primary focus of service development. This is the basis of the prevention of criminal recidivism and further engagement with criminal justice, further problem drug use and unplanned engagement with health and other services and to reduce health inequalities generally and particularly in terms of the risk of premature death. The promotion of recovery and the prospect of stable lives away from involvement in crime and problem drug use and the avoidance of onward transmission of blood-borne viruses represent a significant opportunity for individuals, their families and wider community as well as a significant cost saving in terms of prevention. The prison should, for some people, be a key driver for promoting prevention.
Blood borne Viruses

The lack of provision of injecting equipment provision in Scottish prisons remains an anomaly. It is difficult to justify this given the effort and investment in injecting equipment provision in the community. It is difficult to prove the exact timing of infection and therefore claims that prison transmission rates are very low should be treated with caution, as should the claim that injecting rates in prison are low ‘because we do not find injecting equipment’.

Blood-borne virus (hepatitis and HIV) testing is inconsistent and poorly managed overall in prisons. Some establishments still insist on accessing venal blood rather than using dry bloodspot testing. One consequence is that testing on admission / reception is far less likely as a nurse has to be available. As soon at the prisoner is admitted and inducted into prison gaining a blood sample becomes less likely as they then have to actively seek out a test.

Access to treatment for BBVs in prisons is not confidential and this discourages both testing and treatment. Efforts have been made to enhance access to treatment services however some issues with through-care have impacted on prisoners continuing care on release. Unplanned movement across the prison estate has also led to interruption of, or initiation of, treatment regimes.

Access to condoms and education around sexual health including HIV prevention appears to be very limited.

Death prevention

There are other areas of immediate concern which should be addressed in terms of prevention of deaths in custody. Current practice of overnight observation checks are not adequate in preventing overdose deaths.

- There should be improved practice in terms of observation of prisoner to prevent overdose
- There should be training for staff and the availability of naloxone on every landing and hall.

NHS staff are not present at night. The reported operational issues that people would make constant requests to see nursing staff through the night is an indicator of need, not necessarily a reason not to proceed. A need to improve sleep patterns also exists. These are an indicator of other issues in terms of mental health and prison regime more generally that should not be ignored.

- There should be due consideration regarding whether NHS cover is reintroduced overnight.

It is disappointing that prison supply of naloxone to prisoners on release remains at low levels. It is recommended that -

- All prisoners at risk of overdose, ie all prisoners with a history problem drug use whether they have been using or been in treatment while in prison, should be provided with a take home naloxone kit on liberation. Prisoner opt-outs on this should be a subject of concern and efforts should be made to reduce incidence of this.
Throughcare

Prison throughcare is an essential service that can link care started into prison into ongoing community based care. It allows greater levels of engagement post release and is crucial for BBV healthcare to continue post liberation.

- Communication between prison based and community healthcare systems are assessed for effectiveness then regularly audited
- Peer support networks are made available in prison and on liberation to support reintegration into community i.e. Smart recovery, NA, ORT and me.
- All prisoners are assessed prior to liberation regarding potential drug related risk behaviours
- Support is in place for continuation or initiation on ORT at release. Individuals at risk of opiate overdose are referred to prison through-care services

Older drug users

The prison population is continuing to age, with this there are a substantial number of older people with a drug problem (overall over half of Scotland’s 61,500 problem drug users are 35 and over and this figure will continue to rise for many years to come). Prison Health care must adapt to the increasing demand for health care. Recent research undertaken by SDF have identified that older people with a drug problem have a health profile equivalent to people at least 15 years older than in the general population. Many of these individuals have multiple morbidities include mental health and a range of physical health conditions. There is therefore a need for health care to adapt over the coming years to this changing demographic.

PLEASE NOTE ALL REFERENCES FOR THE ABOVE EVIDENCE CAN BE SUPPLIED ON REQUEST