Caring for people with diabetes in prison

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I can remember, as a new and naïve diabetes specialist nurse 20 years ago, visiting the local prison to see an inmate who had recently been diagnosed with type 2 diabetes. After spending some time enthusiastically promoting the benefits of physical activity and eating healthily, I was dismayed to see that the tea trolley that was wheeled out contained only white bread and a tub of cheap margarine, to be eaten quickly before lock-up for the next 10 hours. The inmate with diabetes had another 5 years left of his sentence to serve and I did wonder how much he would remember when he was released! I also remember feeling very intimidated by the prison environment – very different from the hospital outpatient diabetes clinic I worked in at the time, where the healthcare professional was still the person in charge of the consultation.

Things still seemed grim in 2005 when Diabetes UK published its position statement, *Prisons – Care of People with Diabetes*. It listed care deficiencies in prisons, at the time including lack of care planning and case management, inadequate dietary guidance and inappropriate diet, lack of self-monitoring facilities, inmates not being allowed to keep their insulin with them, and a lack of diabetes training for prison staff (Diabetes UK, 2005). The denial of these basic aspects of diabetes care were at complete odds with the standards outlined by the National Service Framework for diabetes in 2001, particularly regarding the empowerment of people with diabetes to self-manage their condition, described in standard 3 (Department of Health, 2001).

At the time, commissioning responsibility of all aspects of health care in prisons was being handed over from prison services to PCTs (between 2004 and 2006). Inmates were to be treated as temporary residents of the PCT in which the prison was located, in an attempt to enable them to have access to health services that all people were entitled to. It will be interesting to see how prison health services survive the impending dismantling of PCTs.

The challenges in providing good diabetes care in prisons are many. Inmates often have mental health problems, and tend to be smokers and mis-users of drugs and alcohol. Sixty per cent of prisoners in the UK are younger than 30 years and about 0.6–0.8% have diabetes (Marshall et al, 2000). The American Diabetes Association (2008) estimated that of the 2 million people in prisons in the USA, 80 000 have diabetes (4.8%). As the prison population is young, inmates are more likely to have type 1 diabetes, along with the risk of diabetic ketoacidosis and hypoglycaemia.

This group of people with diabetes and complex needs is being supervised by prison medical and nursing staff who are likely to be relatively inexperienced in diabetes management. Access to diabetes specialist staff in outpatient clinics may be difficult if the escort that the inmate will need is unavailable, or inmates refuse to attend if they object to being shackled in public. There has to be a balance between encouraging self-care of diabetes and security needs, with the latter having priority, which is an alien concept for most healthcare professionals.

However, it is not all bad news. For some people with diabetes, being in prison actually facilitates better management of the condition (which is a sad reflection of the poor home environment and lifestyle of these people). In prison their diet is restricted, alcohol limited, and medication is supervised so compliance is improved. They may not have attended a diabetes clinic for a long time so imprisonment results in a review and reassessment of their treatment, and screening for complications. It can also be an opportunity for structured education. Diabetes specialist nurses can make a significant impact on diabetes care in prison as described by the author of the following article working in Northumberland, and others (Leivesley and Booth, 2009). ■