Changing diabetes®

Diabetes in prisons – can we improve the care provided?

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People with diabetes can be faced with barriers to receiving the best possible care. Whilst the majority of people have access to support and services needed to manage their diabetes, can the same be said for those people with diabetes in prison?

Prison populations are predominately male, with an average population of around 15–44 years. They are usually poorly educated and are likely to return to poor circumstances on release (Levy, 1997); however, diabetes care for those in prison should be no different than those who are not. In the past, prisoners have been reported as self-inducing diabetic ketoacidosis by refusing to take their insulin, with the aim of being transferred to hospital (Macfarlane et al, 1992). The care situation was poor when Diabetes UK published its position statement, *Prisons – Care of people with diabetes*, in 2005. The list of deficiencies in prison was long, stating that prisoners were unable to keep their insulin with them in their cells, lack of self-monitoring facilities and a lack of diabetes education for staff.

In 2003, the Secretary of State for Health, John Reid, assumed responsibility for securing a full range of health services for prisoners and it was delegated to primary care trusts to commission services. Since then, opportunities for diabetes services to develop within the prison setting have increased.

Setting up a prison-based diabetes clinic

HMP Risley is a local male prison, with approximately 1100 inmates and a diabetes population of 5.09%, 37% of which have type 1 diabetes and the remaining have type 2 diabetes. A nurse-led diabetes specialist clinic was set up in 2011 and is held once a month. The aim of the clinic is to improve the management of diabetes and to reduce hospital admissions and attendance at outpatient clinics.

So far, the clinic has demonstrated that, in a 12-month follow-up period from October 2011 to October 2012, overall HbA_{1c} levels were reduced from 74 mmol/mol (8.9%) to 58 mmol/mol (7.5%). Episodes of severe hypoglycaemia requiring A&E attendance in the preceding 12 months was greatly reduced from 17 episodes to just one ($P<0.001$). Hospital admission rates were also reduced, with only two admissions in the 12-month period; one admission was due to hypoglycaemia (overdose) and the other due to infection. There were no admissions for diabetic ketoacidosis. The reduction in outpatient visits has meant cost savings of £39 717 for the community trust due to reduced need for transport and escorts.

Education, management and support

Prison staff training is required so that all staff know when to get help and when to consider that a prisoner is unwell and not just "acting up". Many prisoners are locked in their cells for many hours at a time and the risk or fear of hypoglycaemia is great.

Careful management, education and support is required, both for the prisoner and the prison staff. Self-management programmes for prisoners should be considered where appropriate in order to empower prisoners with diabetes. This needs to be done under careful consideration, as there will be some offenders that will still manipulate their diabetes in order to get what they want, such as a visit to the A&E department. Access to medication and education should be reviewed and the commissioning of services for prisoners with diabetes needs to be addressed. Most importantly, prisoners should be offered care that meets national standards. We have shown that providing a nurse-led specialist diabetes service in prisons can reduce hospital admissions, reduce the number of hospital outpatient clinic appointments, improve patient outcomes and, ultimately, save the NHS a substantial amount of money. ■

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