Providing diabetes care in prisons: Experiences of joint working with prison health care

Sue Robson

Article points

1. Prisoners are not representative of the general population. They are predominantly male, aged between 15 and 44 years and poorly educated. Many live on the margins of the community and are likely to return to poor circumstances on release.
2. Studies have found that 90% of all prisoners have a mental health problem, a substance misuse problem or both, and that 80% of prisoners smoke.
3. Since 2000, prison nurses have had greater access to training and professional development, having previously been isolated from their professional counterparts.

Key words

- Prison diabetes care
- Vulnerable groups

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In the UK the provision of prison health care has historically been suboptimal. The quality has been found to vary widely, with prison health services prior to 2000 isolated from the NHS. Reed and Lyne (1997) assessed the extent and quality of health care in prisons in England and Wales, and recommended that expertise should be commissioned from within the NHS. This article describes some of the difficulties in achieving equitable health care for such a group whose engagement with health services may previously have been inconsistent and unplanned.

"The degree of civilization in a society can be judged by entering its prisons" (Dostoyevsky, 1862). Prison inmates are not representative of the general population. They are predominantly male, aged between 15 and 44 years old, and poorly educated. Many live on the margins of the community and are likely to return to poor circumstances on release (Levy, 1997). A custodial sentence, however, can allow access to health care that may have been unavailable or unacceptable when in the community. For this reason, diabetes screening, education and treatment plans often have to be opportunistic, and time needs to be taken to explore prior knowledge and personal motivators.

The modernisation of prison healthcare has been working towards equitable health care and closer partnerships (Prison Health, 2004), and Northumbria diabetes service has, for the past 4 years, been developing services alongside prison healthcare providers in a large category C prison in Northumberland. Category C is a closed male adult prison housing prisoners who cannot be trusted in open space, but are unlikely to attempt escape. This prison has a population of around 900 inmates, and is a training prison with educational and vocational courses. Half of the accommodation is for the main inmates, and the other half is for vulnerable individuals – mainly sex offenders – who must be segregated from the other inmates.

In April 2003, the Secretary of State for Health assumed responsibility for securing a full range of health services for inmates, and it was delegated to the PCTs to commission services on a rolling programme (Joint Prison Service and National Health Service Executive Working Group, 1999). The overall responsibility now lies with PCTs and prison

governors to facilitate healthcare improvements with expectations that the standard of care is no different to that commissioned elsewhere, except that it should be effectively provided within a custodial setting (Gulland, 2002; Prison Health, 2004).

There is very little available literature about providing health care in prisons to inform the setting up of new diabetes services and providing good models. Health priorities in prison are driven by high levels of mental health problems, drug misuse and general poor health among inmates (Bridgwood and Malbon, 1995). Studies have found that 90% of all inmates have a mental-health problem, a substance misuse problem or both, and that 80% of inmates smoke (Gulland, 2002). This means the budget provided for health care remains strained, as addressing mental health issues and substance misuse are priorities for limited resources. Providing care for those with diabetes in this environment can be challenging.

While current aims are for inmates to have access to primary care equal to that provided within the wider community, the starting point on reception can be variable. Some inmates have poorly controlled diabetes on arrival, and their glycaemic control actually improves while in prison due to regular medication, meals and exercise regimens. For others, however, the rigid routines, volatile environment and general lack of understanding about diabetes among fellow inmates and prison staff can cause problems. There is also understandable concern about the risk of hypoglycaemia, with many inmates not prepared to place themselves at risk of an unrecognised or nocturnal hypoglycaemic episode, especially in prisons with no overnight healthcare provision.

Since 2000, however, prison nurses have had greater access to training and professional development, having previously been isolated from their professional groups. The prison practice nurses are now in a position to provide routine diabetes care, cardiovascular screening and health promotion. For DSNs, working alongside the prison nurse provides an opportunity for joint working and the provision of the same person-centred care as within the hospital specialist diabetes clinics, while working within the culture of the prison system. Trust-wide clinical diabetes guidelines are followed, but diabetes treatment plans need to be flexible for individual needs. This is especially important if prison sentences are short and individuals are returning to their usual care providers. For some inmates, release from prison will mean transfer to temporary accommodation, with a proportion being homeless on release. It is also suggested that access to good primary health care in prison can have a real impact on reducing re-offending (Alba, 2004).

Access to computers and information systems have improved, and provide identification of those with diabetes and data for individual reviews. However, prison statistics exclude health data performance indicators such as the Quality and Outcomes Framework, which normally rewards GP practices for identifying and treating people with diabetes, and has been able to demonstrate improvements (Department of Health [DH], 2008a). As these data are not systematically collected, the lack of comprehensive baseline information inhibits the assessment of current services and future needs, and may not provide the same motivators as community primary care providers.

The NHS has itself been undergoing a modernisation programme, and continues to strive to improve standards for people with diabetes and other long-term conditions in line with guidelines, such as the National Service Frameworks (NSFs), and a wealth of publications from the DH, including *Our Healthier Nation: A Contract for Health* (1998a) and *A First Class Service: Quality in the New NHS* (1998b).

The NSF for diabetes (DH, 2003) is now 5 years old, and the recent extensive NHS review led by Lord Darzi acknowledges the need to address inequalities using variations in the way that different groups are able to access services (DH, 2008b; 2008c; 2008d). Partnerships, planned personalised care, and timely access are core aims. These are admirable and ambitious goals, but the reports have little comment or direction to aid facilitating health care in prisons and for hard-to-reach groups.

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2. During the prison retinal screening sessions the author felt it was necessary to work together to provide a chaperone for added safety and to complete the screening session as quickly as possible.
3. Some inmates refuse screening, and a few refuse to attend the hospital appointment with an ophthalmologist because of objections to shackling during external visits. Overall, however, the screening opportunity appears to be well received.

In the author's experience, inmates are encouraged to engage in decisions about their treatment goals and take responsibility for managing their own medication – although they receive small supplies, and supervision may, at times, be required. Joint working with practice nurses has enabled discussions about screening results and risk, insulin initiation and changes in treatment regimens to be achieved on-site as the nurses are now able to provide competent education and supervision. Clearly this environment is entirely different to conventional hospital settings, and the visiting diabetes specialist needs to learn from experienced prison staff about the culture and motivators of this patient group. Support is provided by telephone and flexible clinical sessions in the prison are provided once a month.

For inmates needing a hospital outpatient appointment, an escort is always required. A prison inspectorate reported frequent problems in obtaining staff to act as escorts to outpatient departments, or to act as "bed watchers" for physically ill inmates in hospital (Reed and Lyne, 1997). This leads to frequent cancellation of appointments at substantial cost to the NHS. It is, therefore, now recognised that a member of a specialist team visiting the prison can be a good alternative service model and should be considered (HM Prison Service, 2006).

Retinal screening

Inmates with diabetes are clearly eligible for eye screening. Locally, it would be impossible with current resources and security restraints to arrange individual retinal screening appointments in line with NSF standards. It would not be possible to provide eye screening within the local hospital diabetes clinics, as the current provision of screening carried out in less-secure primary care or community clinic settings.

During the prison retinal screening sessions the author felt it was necessary to work together to provide a chaperone for added safety and to complete the screening session as quickly as possible. There are logistical difficulties in keeping all inmates in external waiting areas, as they have to be escorted to the healthcare facility and there is a need to segregate main inmates from vulnerable inmates at all times. There are also specific lock-down times in prisons, which adds time restraints and shortens clinical sessions. There is usually between 30 and 35 men with diabetes who are offered screening – approximately 3.6% of the prison population.

Some inmates refuse screening, and a few refuse to attend the hospital appointment with an ophthalmologist because of objections to shackling during external visits. Overall, however, the screening opportunity appears to be well received (*Table 1*).

During diabetes consultations seeing people with the condition unaccompanied is usual practice; however, for those who are working in the prisons as a visiting practitioner, safety needs to be an important consideration. The Prison Officers Association suggests that it is important not to consider inmates as "ordinary" patients, as any relaxation could lead to compromised safety (Gulland, 2002). This presents competing priorities when providing the best environment to deliver person-centred care.

The strategic aim, when responsibility transferred to the NHS, was for the financial and performance frameworks to be mainstreamed in the NHS, but the PCT

Table 1. Numbers of individuals receiving retinal screening between 2005 and 2008.

Year	Number screened	Refused screening	No retinopathy	Background retinopathy	Referral to ophthalmologist
2005	33	1	12	17	4
2006	25	0	15	8	2
2007	30	0	17	7	6
2008	33	0	25	5	2

would not receive separate financial allocations. However, it is recognised that the health needs of inmates are greater than those of the general population (Prison Health, 2004).

As the author's visiting diabetes specialist service arrangement was set up around the time that responsibility was transferred to the PCTs, it has proved difficult to revisit local commissioning arrangements as the prison is seen as the "residence" of its occupants, and, therefore, services are already funded and fall into the local community. From a service-delivery point of view, prison sessions can be time consuming in comparison to conventional diabetes clinics.

Conclusion

Meeting the modern NHS agenda to provide high-quality care, treating individuals with respect and dignity wherever health care is provided (DH, 2008d) remains challenging to achieve for people in prison with long-term conditions, including diabetes. Priorities in prisons often centre on staff safety, changing populations, vulnerable groups and individuals who may be living at the margins of society when released back into the community. Long-term conditions may be a low priority in prisons, but with improved health care and practice nurses trained in diabetes, achieving the diabetes NSF standards can still be the goal.

It is now possible that opportunistic screening, education and individual plans of care can be provided. Senior prison staff have a responsibility to help establish links with local primary care or specialist hospital-based services following an inmate's release; however, the ability to ensure continuity of appropriate health care following release from prison is doubtful for many.

As there are security risks and costs when escorting inmates to hospital it may be seen as a more cost-effective and efficient way forward to provide specialist diabetes care within prisons. Taking all opportunities to provide structured diabetes care to this group, especially working in partnership with local diabetes teams, can be effective. The provision of a specialist clinic provides an excellent opportunity for joint working and training of the prison healthcare providers. This service needs to be flexible to meet the needs of the inmates and the staff providing on-site diabetes care.

Providing on-site retinal screening has been the only way to achieve systematic screening locally. Visiting specialists need to work collaboratively with healthcare staff so that they are fully briefed in terms of the prison culture and the complex needs of the group with which they will be working. It is essential to have skilled prison nurses working inside the prison system provide day-to-day continuity and enable every opportunity to be taken to provide individual plans of care initiated on reception. ■

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