Prison Healthcare

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The main issues:

- There is a lack of doctor time spent seeing patients. This results in a demand that doctors take risks by remotely treating prisoners without seeing or speaking to them.

- The prison security regime prevents patients being seen. Security is said to always override healthcare's requirements. Yet the inability for prisoners to be seen increases the security risk, increase the risk to prisoners' health and increases the risk of a death in custody.

- GPs in London Remand prisons work outside GMC Good Clinical Practice Guidelines.

- That Prison healthcare is General Practice medicine is not appreciated, such there is often little equipment. If present it is often not maintained so we are often unable to examine patients. At two prisons I go to doctors cannot examine in reception as there is not even an examination couch. There is compromised privacy with open door and staff coming in and out. There is no ability to do simple clinical tasks in-house.

- Some frail patients now need secure nursing homes. Prisons are unsuitable for them.

- The clinical computer system is not ergonomic and carries risks, especially on looking back in the records.

Funding

Prison healthcare may be overfunded. It is certainly not giving good value. Regularly at the lunchtime hand-over meeting at one London prison there are 35 staff attending for 1,200 prisoners. To compare, eight people would attend the team meetings at my GP practice of 2,600 patients in Hertfordshire (including external agencies). Despite the high prison healthcare staffing levels, prisoners cannot be seen often enough by clinicians.

Ageing Population

Doctors are needed as the primary clinicians as these patients are very complex, not only with the problems of personality disorders and drug dependency, but also difficult medical needs with rare diseases, such as one clinic I saw patients with sarcoidosis, an old gunshot wound with radial nerve palsy and an empyema, Hepatitis C, sickle cell crisis, gallstones and a patient with ulcerative colitis flare. Then there are those who have sedating drug seeking behaviours.

The healthcare team needs to manage the complex care of those with chronic diseases in an ageing prison population. Having specialist nurses for various subjects is not efficient because most prisoners will not have one problem or disease. They will be diabetic with hepatitis C; the dual diagnosis patient will also have hypertension. The complexity is increasing as the prisoners are getting older with historical convictions coming in; the last prisoner I saw this year was in his tenth decade had just his given his first but long (and last) sentence. He was frail with multiple health problems, he was placed in the prison's healthcare, in a locked cell. He and others like him need recategorizing placed in a secure nursing home.

Dements in prison
There are some prisoners bed bound and demented such that they do not know that they are in prison. The healthcare wing is a poor nursing home and is not equipped to handle such patients. Even in healthcare wing frail patients are locked in their cells and clinicians have find an officer to unlock the door to get access. These patients need a place in a secure nursing homes or discharged from prison. Bed ridden, contractions and bed sores are difficult to fake.

Team Working
There have been many attempts to replace GPs in prison Healthcare. Commissioners seek to avoid the expense of doctors. The emphasis on non-medical teams may have come about as commissioners assumed that the bulk of prisoner healthcare needs were psychological. The result is to disperse care over too many other staff, too many teams, increase costs, and increase risk. It places dangerous pressure on remaining doctors' workload (as in "tasks" a computer list of obligations to treat patients without seeing them). The tasks make doctors work at a distance, and this helps destroy team working.

Prison Governors shift costs to healthcare by insisting that healthcare is divided into wing clinics and drug issuing on the wing. For Governors this avoids prisoners having to be escorted clinics or walk to healthcare on free movement times. I recently worked a prison at where everything is still done in healthcare; prisoners go to central healthcare, including for medications. That prison has a smaller clinical team working in fully equipped clinic rooms, with very short or no waiting times, few DNAs, and no expectation to treat without seeing prisoners. Risks are substantially reduced. It is a joy to work there. The healthcare manager regularly resists demands from Governors to disperse the service out to wing clinics.

Turnover may not have been accounted for by commissioners in determining the number of full time doctors required in a prison. 1000 place prison may seemingly need one doctor at day, but in fact the workload is for the 6000 prisoners passing through those 1000 places each year.

Doctors in the London Remand Prison are obliged to work outside GMC guidelines:
Doctors in prison settings are obliged to work outside GMC good clinical practice guidelines. Few doctors want to do this work. It is the prison doctor who seems to carry all the risk for system failures, and it is the doctor who needs to explain everything in the Corner's court.

GMC Guidance includes:
https://www.gmc-uk.org/-/media/documents/Good_medical_practice___English_1215.pdf_51527435.pdf

15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

> *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b. promptly provide or arrange suitable advice, investigations or treatment where necessary*
> *c. refer a patient to another practitioner when this serves the patient's needs.*[5]

We cannot do those things. We need to see the patients to assess them. We cannot see them in a timely manner and see them often enough.

The security regime in London remand prisons do not allow enough patients to be seen. At one prison the last is patient booked in at 11.45, but officers remove unseen prisoners and take them back to their cells at 11.30 as movement stop at 12.00. Instead prisoners that are left or if clinic is running late, should be counted in healthcare as for the roll call, and taken back when last patient has been seen.

Prisons accept Did Not Attend (DNA) rates of 30% or more as normal. It is not; GPs in outside practice never have DNA rates above 5%. Systemic errors prevent the prisoners knowing of their internal appointment and then have problems getting to the appointment, it is not usually the prisoner's fault that he did not get to the clinic. Waiting times to see a GP in these prisons are many weeks. This adds to frustration and aggression on the wings.

Even when we get to see a prisoner we may be put into a room where there is no examination couch or curtain. Even where there is a couch the other essential equipment is missing or broken. Doctors usually are working alone in the room.

No telephone number for translation service as some establishments. We should not use other prisoners to translate. Google translate has its limits.

GMC guidance:
16. In providing clinical care you must:

> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*[6]
> *b. provide effective treatments based on the best available evidence*
> *c. take all possible steps to alleviate pain and distress whether or not a cure may be possible*[7]
> *d. consult colleagues where appropriate*

There is that task list (treat and not see) which breaks 16(a) alone. The task demands are made up of repeat prescriptions, new prescription and actions requests from wing nursing staff. Incoming letters and blood results need reading and actioning. This process is dangerous as we are unlikely have any personal knowledge of the patients. We need to discuss with prisoners how to come off prescribed medications.

Many prisoners come into prison on risky medication combinations, such as methadone and pregabalin, which taken together increase the risk of death in custody. The default action on dealing with the task list is to repeat the medications, feeling that is safer to do as we cannot see the patients. The result is polypharmacy with far too many repeat prescriptions for sedating drugs such as mirtazepam, clonazepam, tramadol, olanzapine pregabalin and gabapentin. Those patients with chronic diseases, such as the diabetic and asthmatic patients are poorly followed up.

Confusing Primary and Secondary care roles in prison
On the outside, primary care service makes a referral and in return receive a plan for a patient. In prisons patients are seen directly by differing specialist teams and partially managed by them. There is seldom any formal handover between the teams. We simply rely on the common medical record. There is no section that is seen to oversee a patient's plan, let alone the prisoner, who cannot get a handle of his own care as he is passed around the system seeing everybody except a doctor. There will be the primary care team, wing nurses, mental health, substance misuse, dual diagnosis, chronic disease teams or clinics, and teams such as sexual health and hepatitis C clinics. There will be an HIV service. But it is the GP who prescribes and deal with results and correspondence from all sources often without seeing the patient.

Hospital Referrals
The lack of GP time with prisoners increases the number of prisoners who are be sent out to hospital. Long waits to see a GP turns routine issues to become emergencies. We cannot do things in-house such as simple tasks such as skin biopsies and suturing of many of the lacerations. There is an X-ray machine unused; prisoners go out. The high rate of escorted visits to hospital means that there are often no escort staff available so that a prisoner on a two-week cancer waits can have his clinic appointment cancelled at the last minute.

Video conferencing is not an answer. Better relationships with the hospital and communications in general a better approach, together with creating the ability to do more in-house. Video conferencing consultant services are often out of district. A video linked consultant may suggest a procedure or operation. The local hospital consultant will still arrange to see the patient in outpatients before adding to the local operation list. There is no saving. Follow up advice is better achieved by phone and letter, it does not require a booked video appointment.

Hospital Appointments and prisoner movements. A prisoner may have an appointment at one hospital and then moved to another prison. A new referral must be made from the new prison. The prisoner's wait starts again as he goes to the bottom of the next hospital's waiting list. The prison service cannot put every prisoner who has a hospital appointment on a medical hold. There should be regional common waiting lists for prisoners, rather than each hospital having its own. Prisoners are unique in moving locations so rapidly. They are not simply moving to a new house.

Discharge Planning. This remains a mess. We may not know the area the prisoner will be living in until too late. Those with multiple convictions and short sentences are particularly problematic.

Telephone consultations within Prison.
Some prisons have restricted landline telephones in the cells. Currently they cannot use these to communicate with healthcare. I have managed to ring prisoners back when they DNA'd, but care is needed as many have shared cells. We are not using this simple resource.

Mental Health and Sectioning in Prison
There are relatively few patients have mental health issues in the traditional sense such as with true schizophrenia, endogenous depression and bipolar disorder. Sometimes it seems that the patients are given labels picked out of Diagnostic and Statistical Manual of Mental Disorders (DSM–5) because they are deviant. If your behaviour is deviant, then you are a psychiatric case. A label or diagnosis of this sort can make some prisoners feel hopeless that they have a disease and cannot change and then doctors fail to cure them of it. There are many psychological issues that are not currently amenable to direct medical treatments. These conditions may be more amenable to a whole prison approach and activities. Many prisoners have drug dependency issues and personality disorders. On the outside these are managed by GPs in primary care services as these patients are discharged from psychiatric services.

Those few who do go psychotic, arranging further for them care is very problematic and very time consuming. Section 48 and 47 of the Mental Health Act are usual routes for transferring the severely mentally disordered to hospital. Near to the release date this is hopeless as The Ministry of Justice needs the receiving responsible clinician at the secure hospital to confirm a bed and treatment is available before the ministry will issue a warrant for transfer. Doctors need to have at least five working days before release date with a bed identified to obtain a section 48 or 47 warrant. This is often not the case in a remand prison, so other methods applied. A Baldrick Cunning plan is then employed for a psychotic prisoner who is at risk of harm on discharge from prison: The police are called, ambulance held standing by. As soon as the prisoner is released and walks outside the gate the police use Section 136, then the ambulance takes him to casualty. Casualty arranges the admission to a psychiatric unit. Astonishingly I have witnessed this work.

Prison Healthcare Computer system
Each time there is a Coroner's case or an accident, it seems that another tick box is added by administration to templates on the computer. Templates do have a role, but their use has got out of hand, and most nurse consultations are template based. Each time a prisoner moves prison he is subjected to the same questions at reception. The nurse ticks the boxes on the system's templates. This process fills up the record with repeated codes of yes/no answers. The templates prevent engagement with the prisoner and blocks hearing his story. The nurse's role is reduced to filling in templates and ticking boxes while glaring at the computer.

TPP, System One, the Clinical IT System using in English prisons is not fit for purpose. It was originally imposed on English prisons without any tender process. I did object at the time. Its advantage is that can now see the full clinical records from other prisons, as this is a single prison service system.

Even so, moving prison requires starting new template entries in reception and then re-prescribing medications.

Scanned or electronic documents, such as is letters from hospital and GPs are a mess on the system as they are not labelled and coded correctly. A clinician needs to read each or many documents to find anything clinically relevant. A document labelled “letter from hospital” is likely to have no clinical information at all other than the date and time of an appointment in 2010. The next letter may be called “appointment” and this is one that has the three-page hospital discharge summary with critical information and advice.

Medico-Legal Cases
The doctor or nurse seeing a prisoner seems quite unware of previous clinical entries, even if the patient was seen moments before by someone else. This is the common theme in the all medicolegal cases and complaints that I have reported upon.

The clinical system almost blanks out the screen for each new consult. The clinician must make specific key or mouse press to draw down today’s earlier entries with the past records. This may take moments to load. The past record’s presentation can appear scrambled with unhelpful multiple template entries. Finding the relevant letter is tedious.

Overstretched clinicians will only respond to the one presenting problem as the prisoner states it, ignoring all other outstanding matters. This habit is partly a consequence of the high turnover in remand prisons. The clinical system makes that situation worse because looking back in the record and finding relevant clinical letters is made so difficult. Clinical coding is poor.

Care Quality Commission
I wrote to CQC and the provider’s chief executive as risks at one prison were risks were so high. The is said to have passed the service. If the service was passed, the CQC must feel obliged to apply lower standards for prison health services than are applied to GP practices outside. Such a policy is at odds the obligation to provide the same level of healthcare as on the outside.
https://www.gov.uk/life-in-prison/healthcare-in-prison

GP Indemnity Costs:
Most prison doctors have to fund their own medical indemnity when working in prisons. This is another factor that discourages GPs to work there. At a prison where healthcare service is run by an NHS Trust, the GPs should be able to join the NHS Trust’s own indemnity scheme. The Trust avoids this by subcontracting to a limited company, who then employs the GPs.

Doctors Cause Crime (and diabetes)
There has an exponential in the use of gabapentin and pregabalin medication amongst prisoners over the last decade. These drugs are now almost exclusively used by those with other dependencies in prisons. During this time of increasing use of these gabapentinoids and other prescribed medications, we are seeing an increase in violence in prisons. The violence may be not be due to illicit Spice use and the past reductions in the number of security staff.

I am the suspicious that us doctors may not be doing any good. Doctors do not have any medication to treat crime, but our best of intentions may now be causing criminal side effects.

Many of my prisoner patients have recognised themselves in the following scenario:

You have a criminal tendency, making you feel nervous, or you have heroin habit, whereby you have to "find" £100+ a day for that. This make you very nervous, an anxiety state. You go to your kind GP who gives you diazepam at least, but clonazepam is your preferred benzo choice (10x more potent). You now feel relaxed and invulnerable. You feel better inside yourself, but you are now worse to others. You can thieve more. Then there is that paradoxical aggression these medications give, so that knife you have with you is now more likely to be used. Of, course you prefer the similar effect given by the gabapentinoids, the new benzos, which you can seek for that old ankle fracture and back pain. Gabapentinoids they make heroin highs better and cheaper, and any spare capsules can be sold on.

Your life is now a mess, and you feel grief, guilt and remorse. These are uncomfortable sensations, which should protect you from more damaging high-risk behaviour. These feelings are depressing and annoying. Your GP now adds in an SSRI for your "depression", preferably Mirtazapine, as you cannot sleep (partly caused by the cocaine), and you want a bit of weight on. The SSRI detaches you from your emotions, releasing you from guilt.

You now have ideas that others do not like you, you have no insight as to why that is so. Your mood swings are violent, disinhibited, so now you now have added quetiapine or olanzapine to the cocktail. These major tranquilisers block all further imagination and hope and make you fatter.

With this concoction of these prescribed medications you now are free of anxiety, grief, guilt, remorse and hope. You have no feelings for others. You now have full blown Iatrogenic antisocial personality disorder with multiple convictions.

Weight goes on and on, blood sugar rises. You are now diabetic.

The government seems to be aware of some of the dependency issues at least
https://www.gov.uk/government/news/prescribed-medicines-that-may-cause-dependence-or-withdrawal
The Parliamentary Under Secretary of State for Public Health and Primary Care has commissioned Public Health England (PHE) to review the evidence for dependence on, and withdrawal from, prescribed medicines. The review was launched on 24 January 2018 and is due to report in early 2019. benzodiazepines, Z-drugs, GABA-ergic medicines, opioid pain medications, antidepressants medicines above that are prescribed to treat anxiety, insomnia, chronic non-cancer pain and depression community prescribing.

Solutions?

1. The number of patients seen by prison doctors a year should be a prison service, Governor's target. This responsibility of Governors seems to have fallen away after the NHS took over healthcare from the prison service. Only a Governor, not NHS staff, can get prisoners to the clinics. In order to be similar to outside General practice, number appointments seen during the day by a doctor can be estimated at 5.5 x population plus turnover of a prison a year.

2. The clinical computer system needs improving. They say there is an upgrade coming but I have not seen it.

3. The role of templates, which reduce nurses to clerks should be rationalised.

4. There needs to be enough doctor time employed for each prison determined by the turnover.

5. Prisoners should be able to go on a regional common waiting list, so when moving prison, as they do often they do not go to the bottom on the local waiting list.

6. Changes in prescribing in the community and some prisons needs radical reduction. The proposal to make pregabalin and gabapentin controlled drugs is welcome.

7. Reform mental health acts in relation to further care.

8. Provide Secure nursing homes for frail elderly prisoners.

CV

I trained at St Bartholomew's Hospital, London. I lived in Hackney and worked in East London for 29 years before moving to Hertfordshire in 1993. I worked in a large East End of London General Practice serving a diverse and multi-ethnic community from 1984 to 1993.

I started in prison health care in 2001 at HMP The Mount Hertfordshire, which is a Category C training prison. In 2008 my company Archway Development and Consulting Ltd and my clinical practice (Archway Surgery) won the competitive tender to continue primary care provision at HMP The Mount. I retired from Archway Surgery in 2008.

In 2006 I provided medical cover for a specialised practice for the homeless and drug dependent patients in Watford, where I met a lot of ex-prisoners needing considerable input.

In 2007 I was employed by Secure Healthcare, a social enterprise organisation dedicated to the provision of prisoner health services at HMP Wandsworth, a category B local prison. l left in November 2008.

I was a Clinical Adviser to the Healthcare Commission 2007-2008, providing reports on complaints made by prisoners on their healthcare whilst in prison. I have provided reports for HM coroners as an independent expert, and I wrote reports for medical defence societies and am an expert witness for medical claims.

I was an NHS Connecting for Health Clinical Safety Officer until 2012. That work involved looking at clinical safety in relation to clinical software development and deployment.

From 2002 to 2011 I was a GP appraiser (West Hertfordshire PCT) appraising GPs and their professional development plans.

2004 to 2006 I was a Primary Care Trust assessor of the quality of GP Practices' care with the Quality and Outcomes Framework element of the GP contract.

Royal College of GPs Drug Dependency Courses in 2008

2009-2016 my main practice was based in a polyclinic in Queensland, Australia. From there I worked in Tristan Da Cunha, Indonesia, Guinea Conakry, Antarctica, Gabon and Falklands, the latter included the care of eight prisoners. Since 2016 I have returned to UK practice and worked sessions at GP practice on Shetland Islands, HMP Holloway. HMP Colchester and HMPs Pentonville, Belmarsh Thameside, Isis and HMP The Mount. I do the occasional prison medical legal report and medico-legal visit.

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