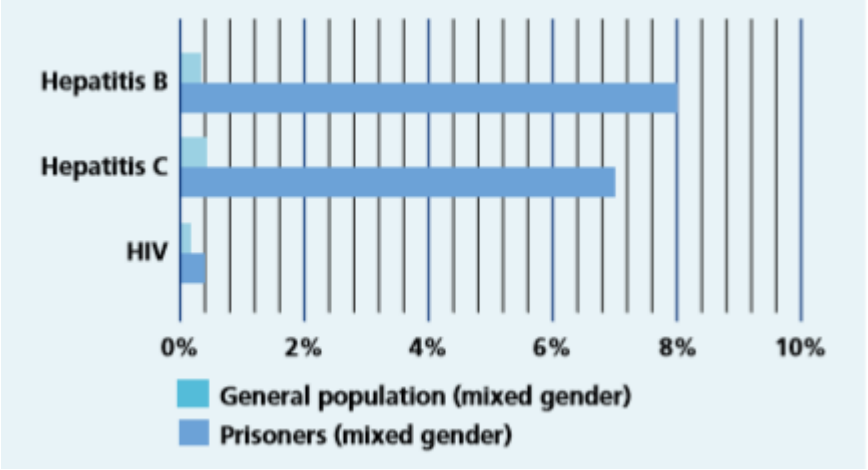
Improving medical aspects of discharge from Prison

Alan Schoflied	Service user representative	
Alastair Boyd	Addiction Psychiatrist	HMP Wandsworth (SLaM)
Louise Mead	Health care administrator	Feltham YOI (Care UK)
Rudiger Pittrof	Sexual health and HIV doctor	HMP Brixton, FYOI (GSTT)
Serina Aboim	Homelessness Nurse	GSTT
Vaneesh Singh	Prison GP	Feltham YOI (Care UK)

The Problem

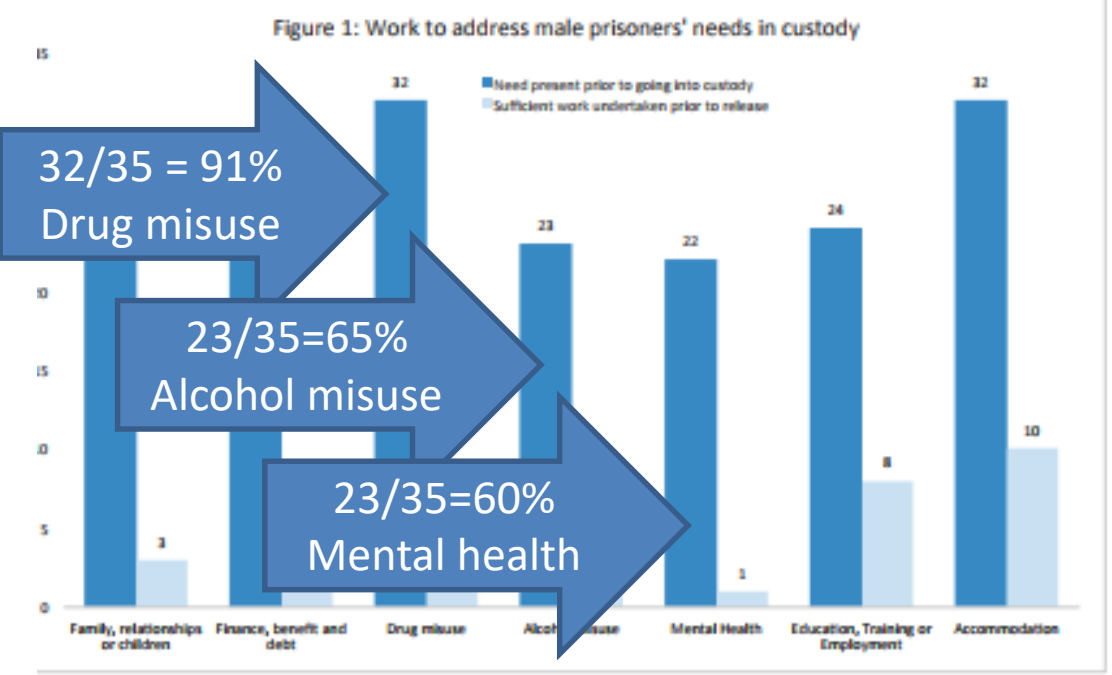
- Prisoners have a high prevalence of medical problems that require continuation of care after discharge from prison.
  - Mental health
  - Substance misuse
  - hypertension, diabetes,
  - asthma and COPD
  - HIV/Hepatitis B & **C**

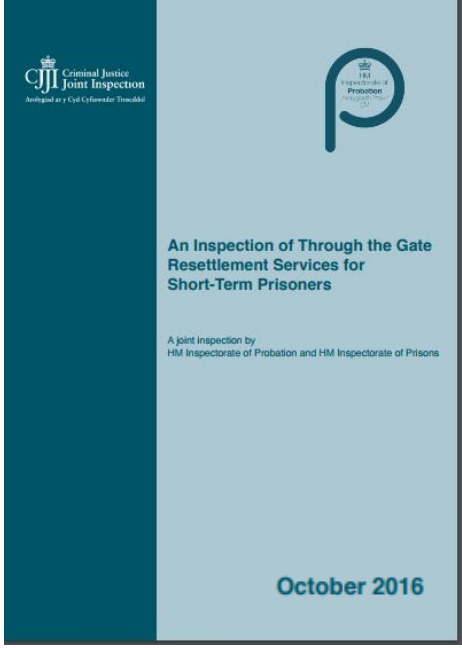


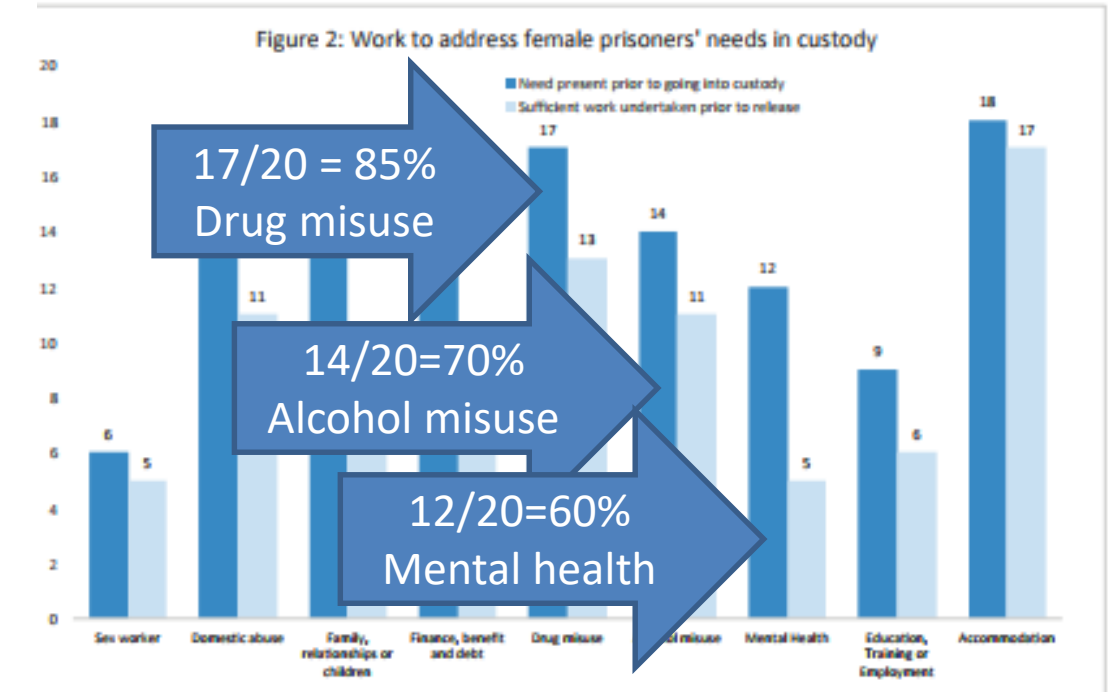
https://www.england.nhs.uk/wp-content/uploads/2016/10/hlth-justice-directions-v11.pdf

Public Health England. Health and Justice Health Needs Assessment Template: Adult Prisons 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331628/Health_Needs_Assessment_Toolkit_for_Prescribed_Places_of_Detention_Part_2.pdf

- Good care in prison is too often discontinued at discharge which may increase the risk of reoffending.



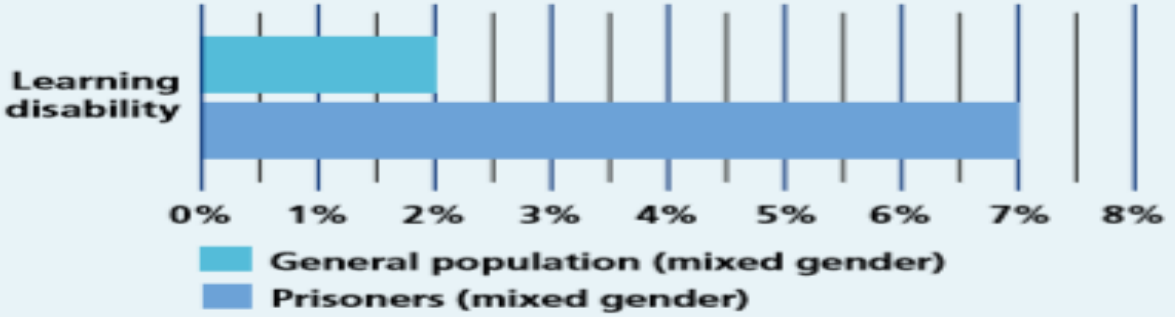




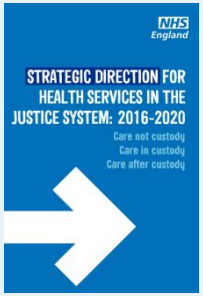
https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf

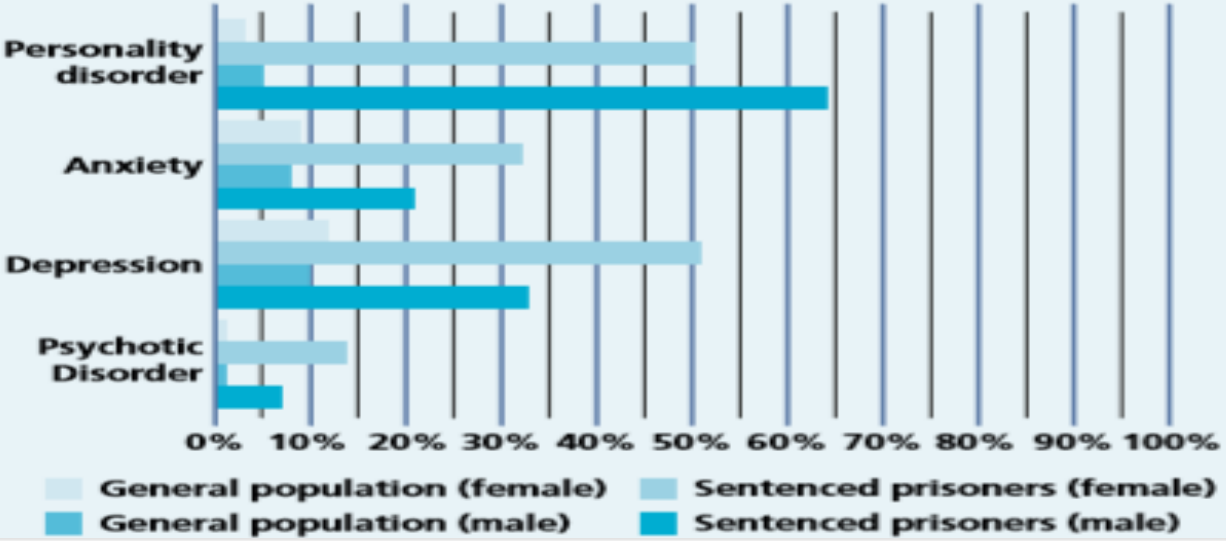
- HMP Wandsworth
- HMP Preston
- HMP Birmingham
- HMP New Hall

Learning disabilities and difficulties among people in contact with the criminal justice system

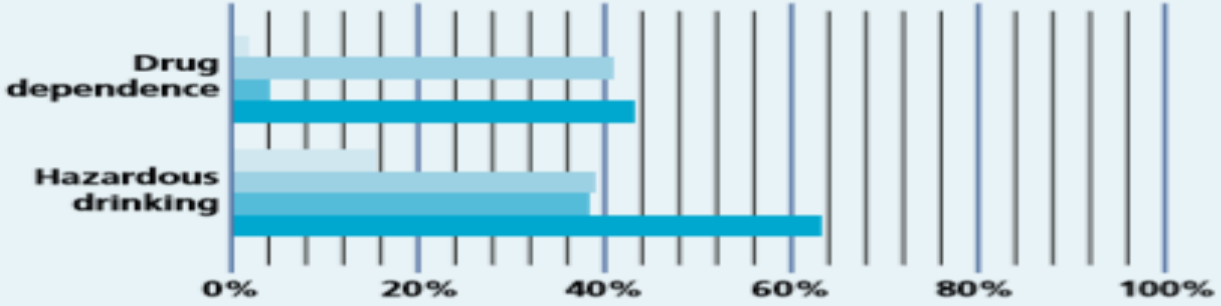


Mental health of people in contact with the criminal justice system





Substance misuse amongst young people in contact with the criminal justice system



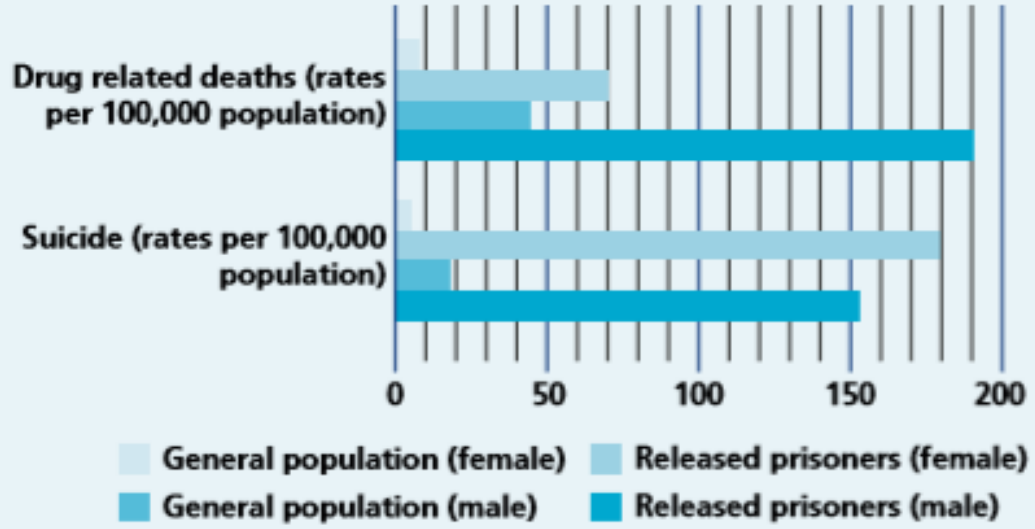
Graphs reproduced from Revolving Doors Agency, Balancing Act: Addressing health inequalities among people in contact with the criminal justice system (2013).

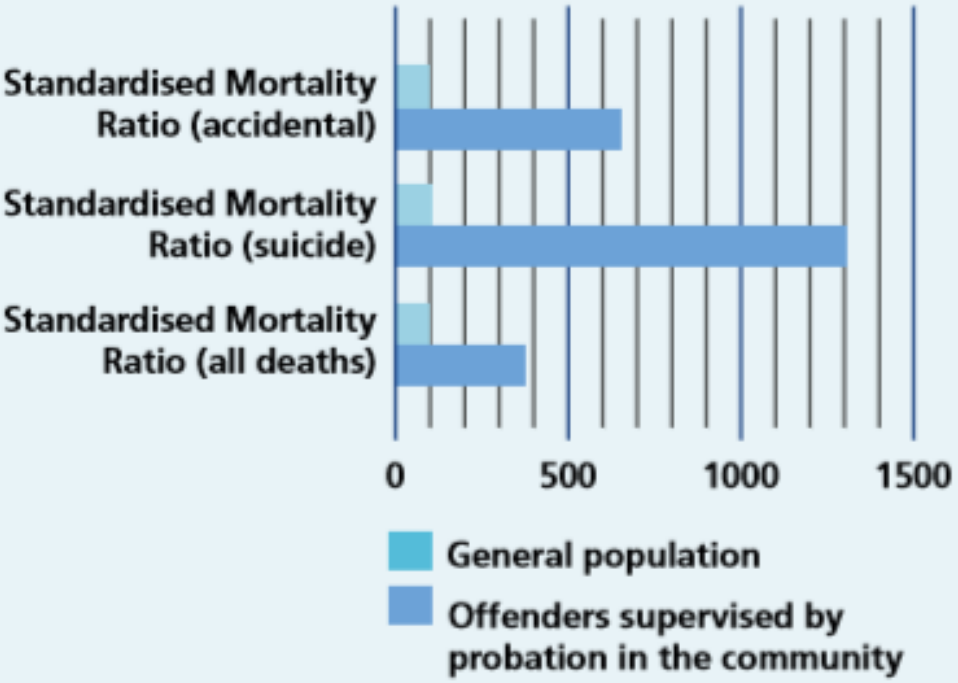
NHS England

STRATEGIC DIRECTION FOR HEALTH SERVICES IN THE JUSTICE SYSTEM: 2016-2020

Care not custody
Care in custody
Care after custody

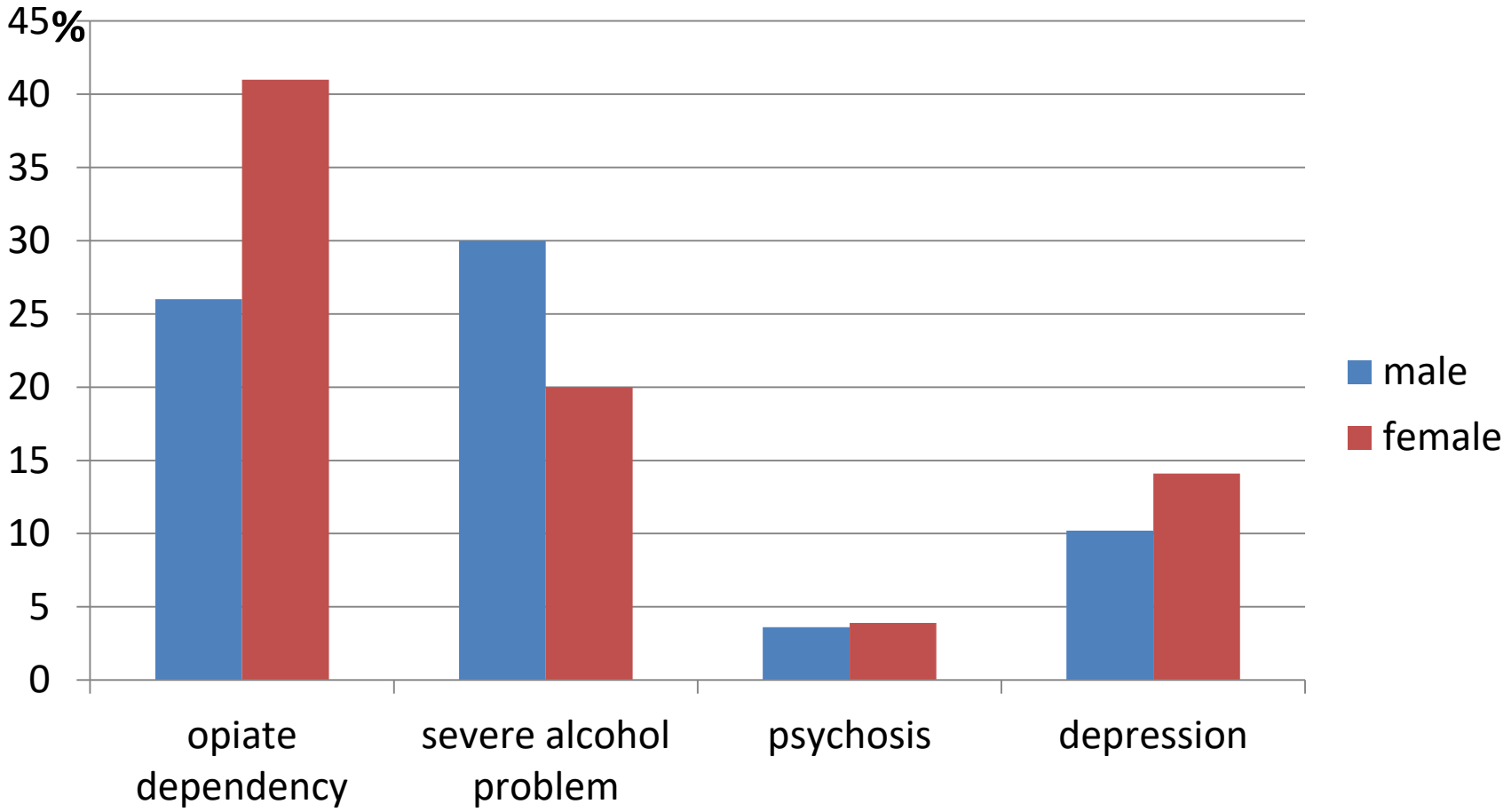
Risk of premature mortality among people in contact with the criminal justice system





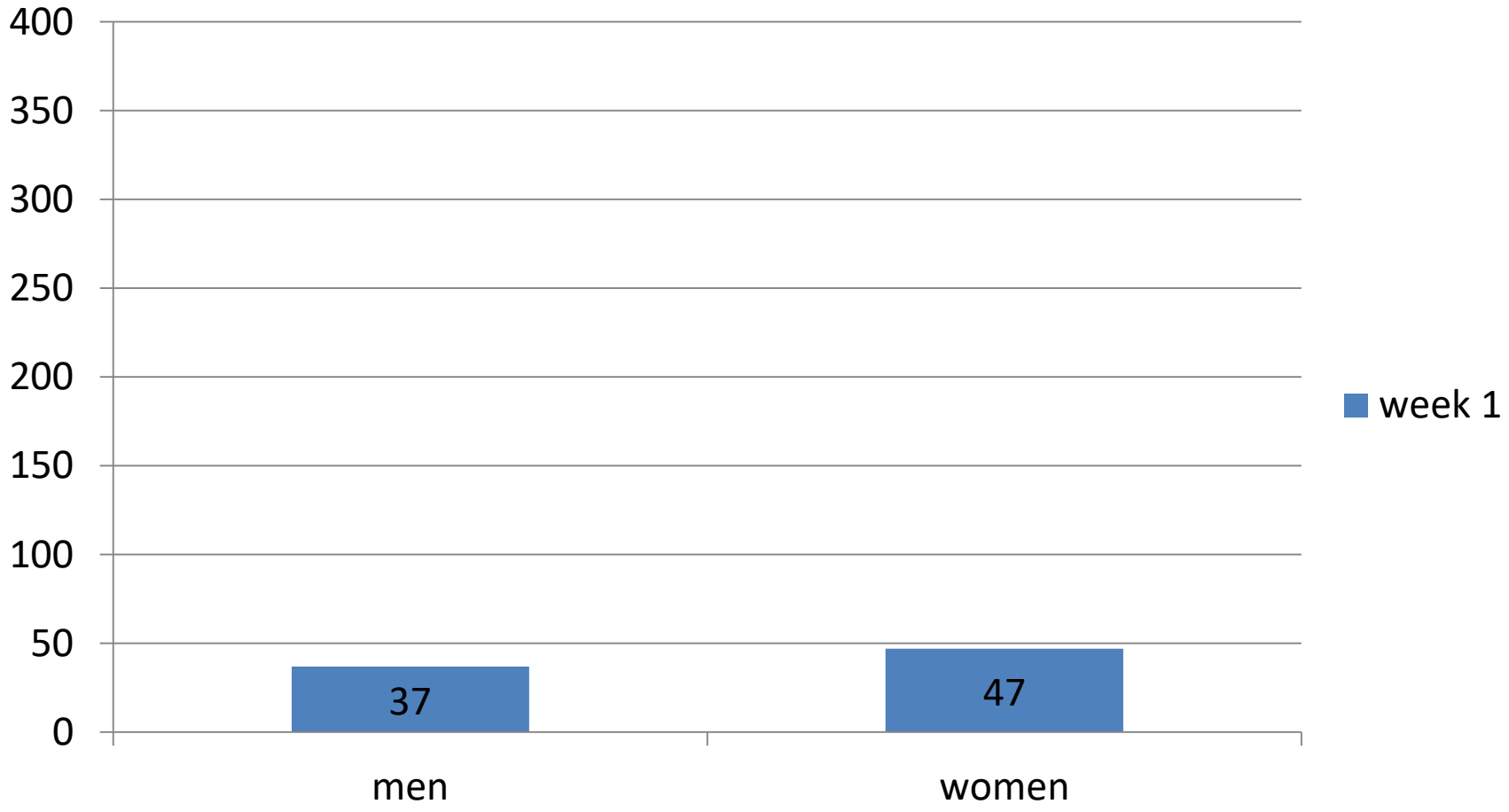
https://www.england.nhs.uk/wp-content/uploads/2016/10/hlth-justice-directions-v11.pdf

Mental health on admission to prison



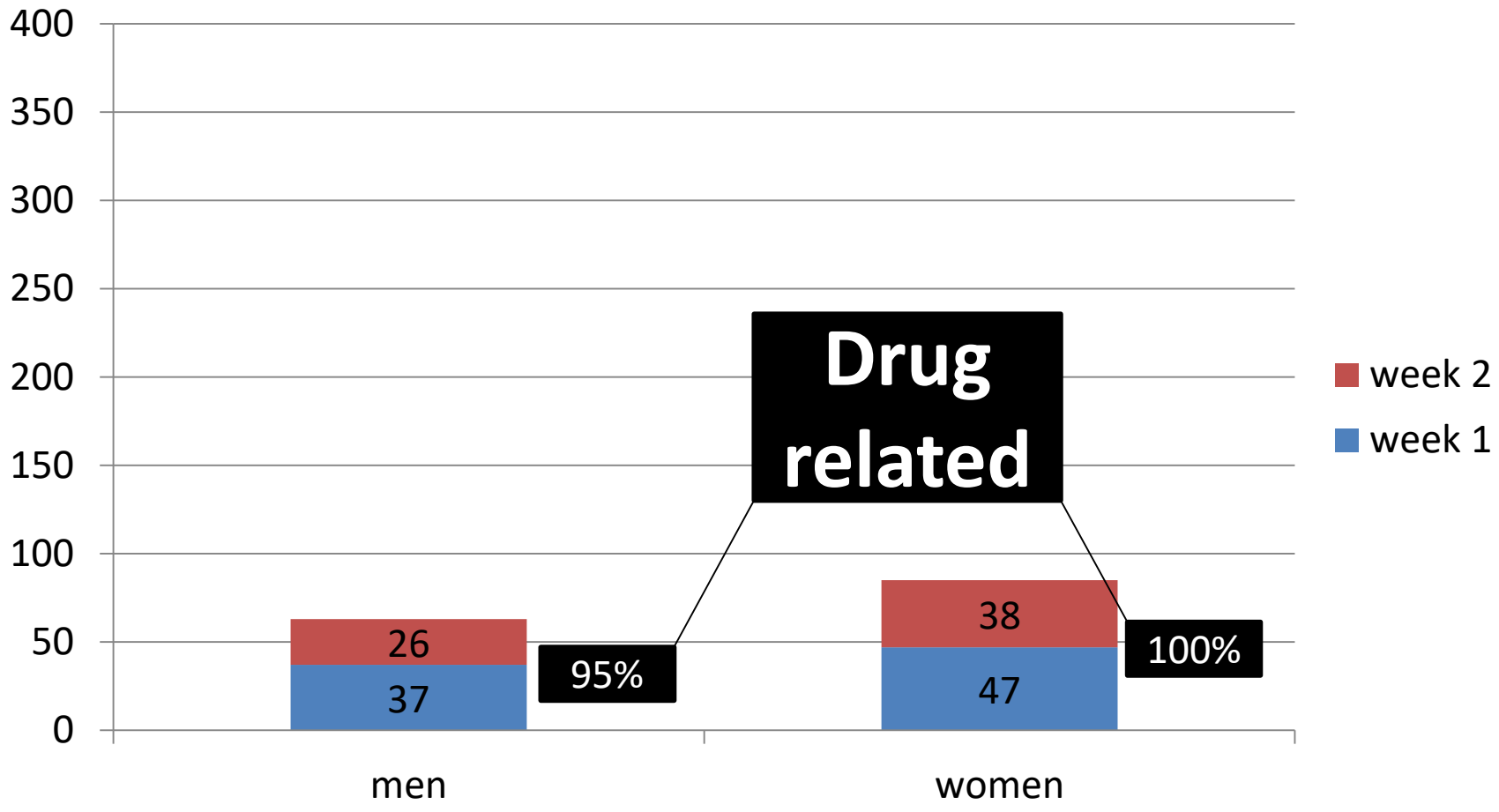
Fazel, S. & Seewald K. (2012) Severe mental illness in 33 588 prisoners **worldwide**: systematic review and meta-regression analysis The British Journal of Psychiatry200, 364–373.

Death within 1 week from prison per 1000



Farrell M, Marsden J. Acute risk of drug-related death among newly released prisoners in England and Wales. Addiction. 2008;103:251–5.

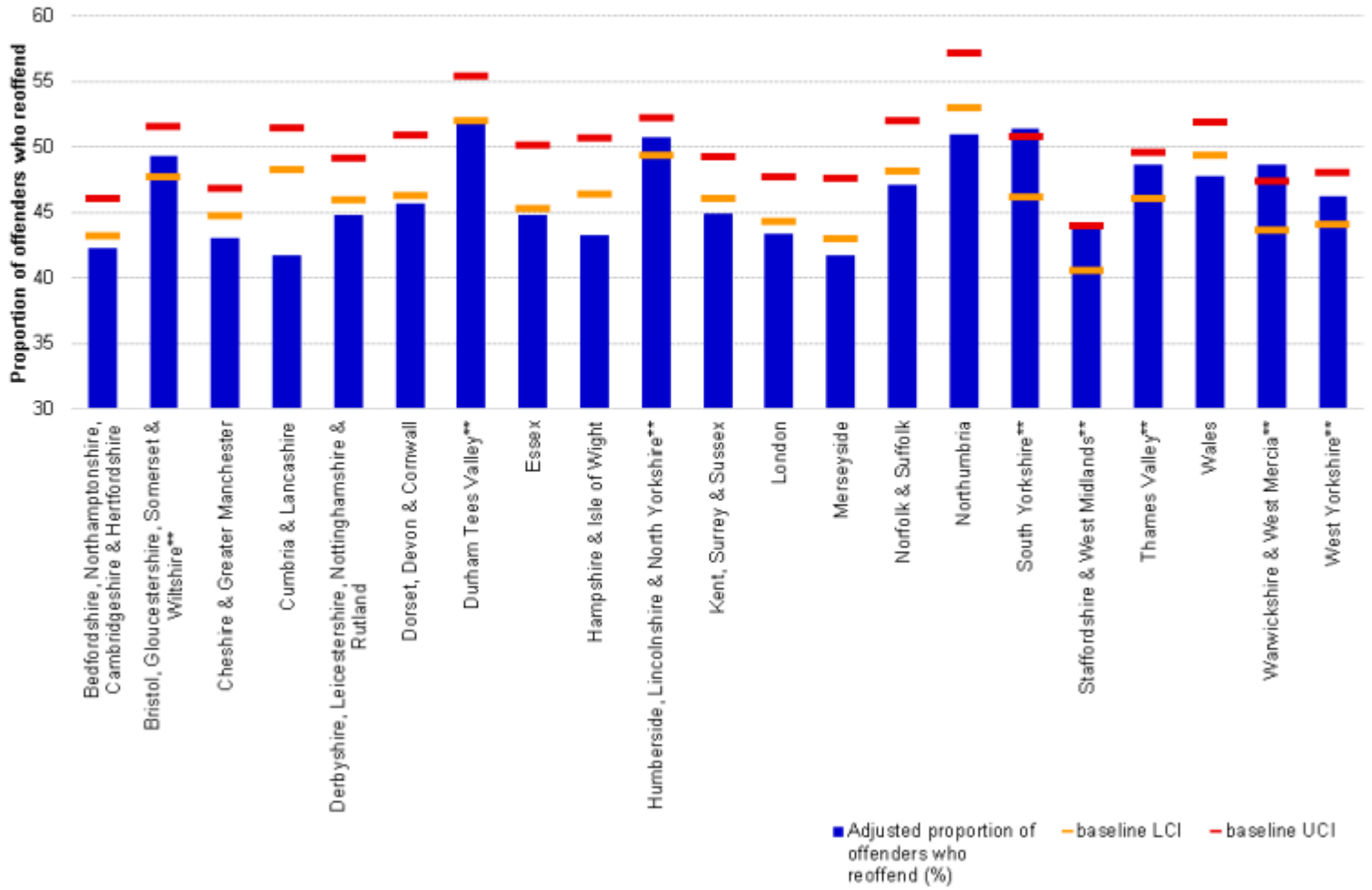
Death within 1 and 2 weeks discharge from prison per 1000/year



Farrell M, Marsden J. Acute risk of drug-related death among newly released prisoners in England and Wales. Addiction. 2008;103:251–5.

In a cohort study of 76 208 persons released from prison in Washington State Bingswanger et al 2013 found an all-cause mortality rate of 737 per 100 000 person-years = 0.7% per year.

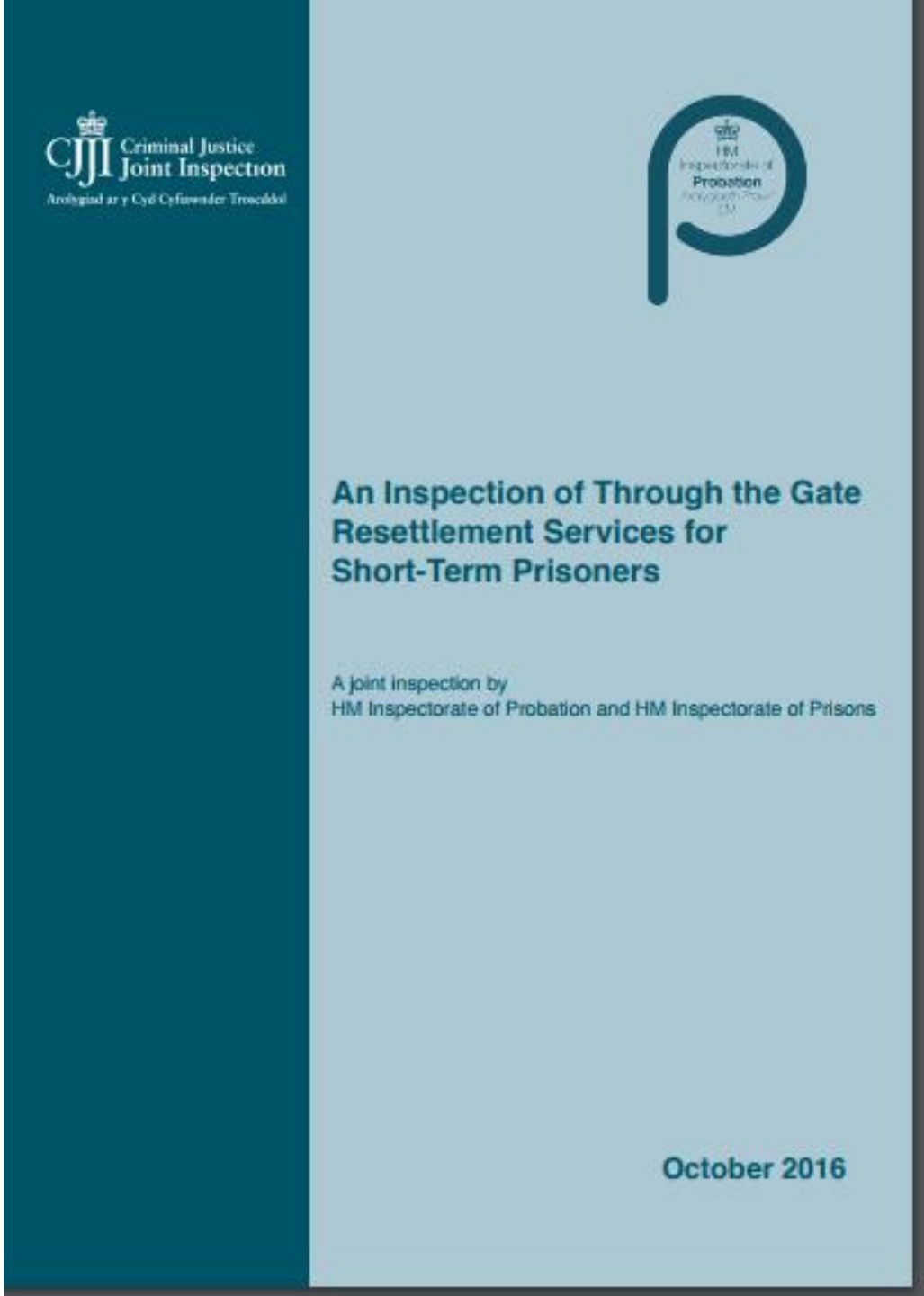
Figure 1: Final rates for proportion of offenders who reoffend for the October to December 2015 payment by results cohorts, by CRC (Source: Table 1)



https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/658382/crc-nps-interim-results-bulletin-oct17.pdf

- Proportion of prisoners on custodial sentence of less than 12 months, who reoffend within a 12 month period after release (October 2013 – September 2014): **60%**

https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf



Reoffending and SMI/addiction

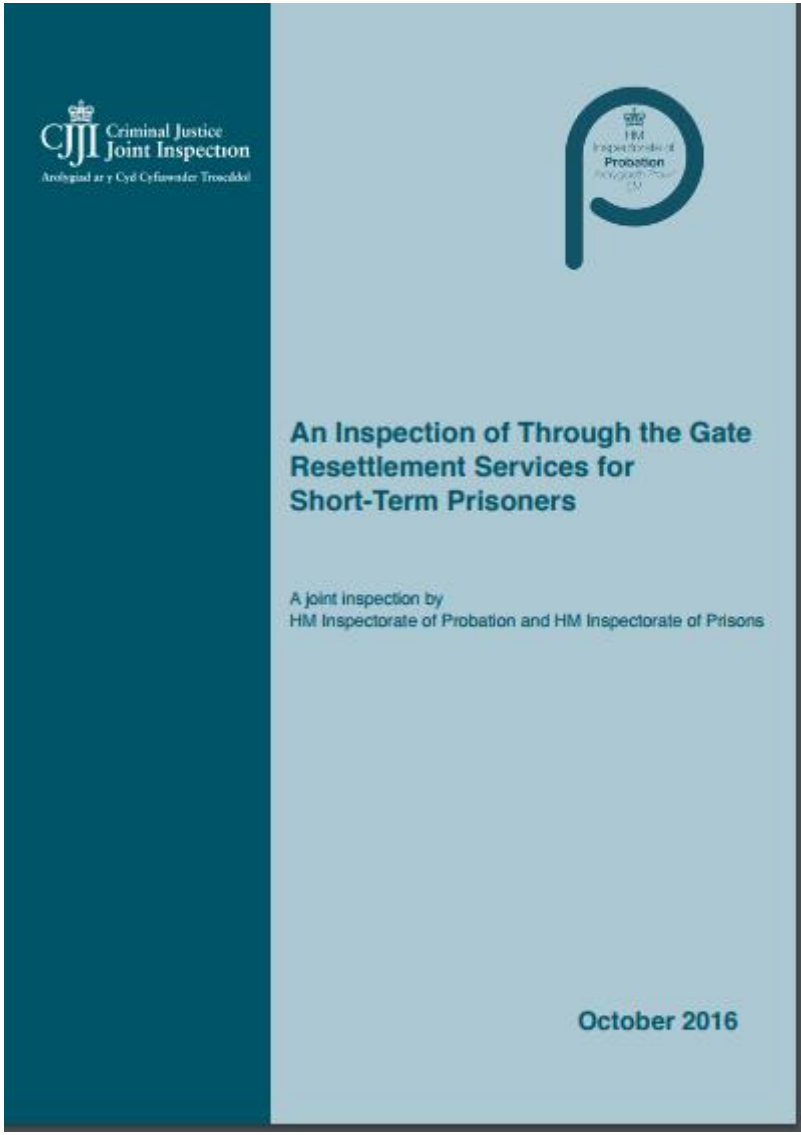
- Poorly managed serious mental illness increase the risk of reoffending Baillargeon J, et al Psychiatric disorders and repeat incarcerations: the revolving prison door. Am J Psychiatry. 2009 Jan;166(1):103-9.

Why are things so bad?

Minimum requirements for resettlement

- A safe place to sleep, from the day of release
- Access to enough money to meet basic needs including food, clothing, and transport
- A sense of hope for the future
-

15% of male prisoners
13% of female prisoners
were discharged to NFA



The day of discharge from remand

- You get your medicines **(8 am)**
- You go court and walk away as a nearly free wo/man (a good surprise) **(9 am)**
- You walk to the bus stop and take bus back to your own borough **(11 am)**
- You walk to probation office - Wait to be seen → have appointment **(12.30 pm)**
- You walk to housing office - Wait to be seen → have appointment **(2 pm)**
- You walk to hostel and check in **(3 pm)**
- You walk to your old GP (luckily you are still on their list)
  - Wait to be seen → have appointment get script for asthma medication and mental health medication. (**4 pm)**
- You walk to addiction centre - wait to be seen → have appointment

  → Too late for an assessment come back tomorrow. **(5pm)**

No methadone = go into withdrawal or visit our old dealer and spend the rest of the money you got on release on drugs.

Do you think that this is realistic?
(like walk to your GP, be seen for asthma and mental health and be discharged all within 1 hr)

- When in prison you have few rights but also few responsibilities.
- You are told what to do and when to do it
- You may have low literacy
- You may have a mental illness or learning disability
- Facilities you knew from before your incarceration may have closed/moved/changed opening times
- The outside world can be confusing for a prisoner
- You may prioritise seeing your partner and your children.

- Prison health care should be providing the same standard of care as on the outside.
- No GP or outpatient department would send patients away with script or medicines for one day only.
- **Why are prisons not providing scripts for a week after discharge?**
  - Costs
  - Who takes responsibility if the patient overdoses?
  - Does the death of a person released from custody count as a death in prison if s/he was on a (methadone) script issued by the prison service?
  - Tradition?

How likely is it for a patient to overdose if s/he is receiving supervised methadone in a pharmacy?

How do we make things better?

- Better data collection
- Better communication
- Better prescribing

- **To reduce deaths after discharge from prison we MUST measure them routinely.**
- **A death related to custody needs to be defined differently (may be akin to maternal death).**

Maternal death is the **death** of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

How do we make things better?

- Better data collection
- Better communication
- Better prescribing

- **To reduce prescribing errors in the community we need to communicate clearer. If the patient does not agree to electronic communication s/he has to carry a letter.**
- **Communication needs to occur before discharge.**

At the GP there is no letter from the prison as you were admitted on remand and the medical dept did not know that your trial was coming up. You didn't want everyone to know about your time in prison so the prison GP and psychiatrist didn't enter your information on the NHS spine. Drug induced psychosis or not you are not going to tell your GP that you were on risperidone. Risperidone causes sexual dysfunction and you want to make up for lost time. You tell the GP that you need gabapentin 1.6 g three times a day and clonazepam 3 mg g three times a day because you had fits in prison. Your GP checks the doses and notices that they are a bit on the high side prescribes them anyway for a month. (this story would make Alastair cry)

How do we make things better?

- Better data collection
- Better communication
- Better prescribing

- In prison only medicines that are hard to overdose
- Use depot medication were reasonable particularly prior to discharge
- Give 1 week medicines supplies at discharge apart from controlled drugs
- For patients who are stabile on methadone arrange supervised dispensing via a pharmacy of his/her choice for one week after discharge. During this time s/he has to visit his/her addiction centre.

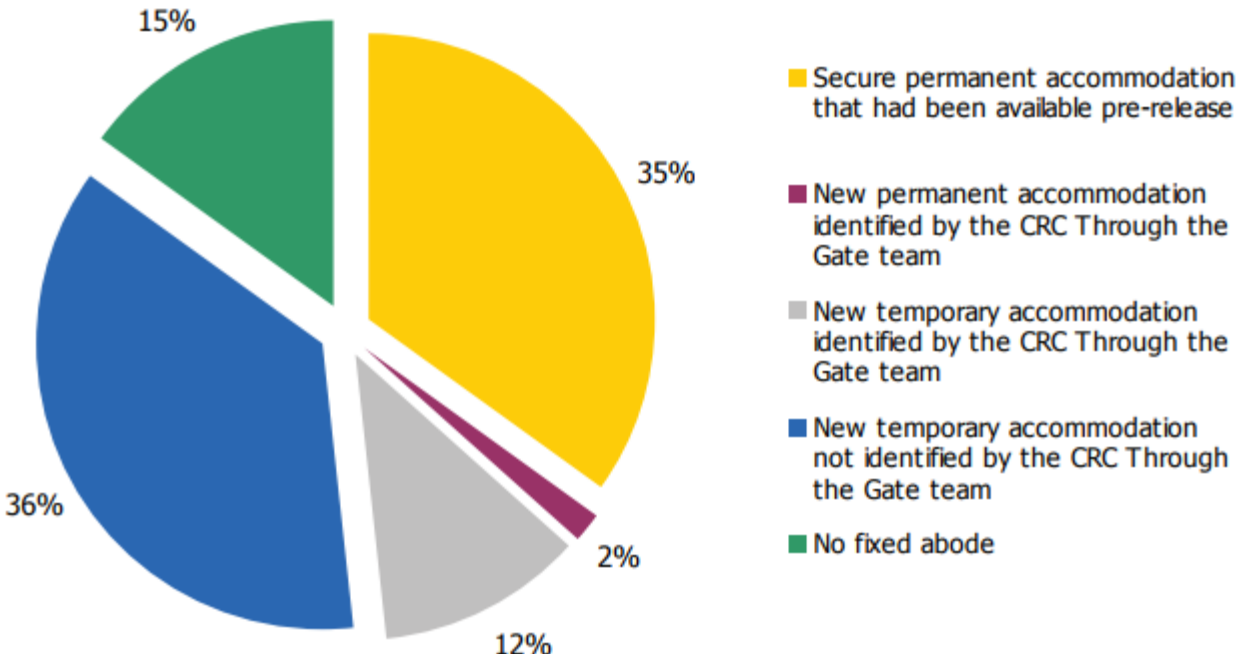
In an ideal world

- Prisoners agree to their prison GP using the NHS spine and are discharged with a letter in their hand to their GP/psychiatrist.
- All prisoners who have ever taken opiates or have ever injected drugs are discharged with Naloxone.
- In the week before discharge prisoners get **Release on temporary licence** (**ROTL**)
  - To visit their GP
  - To visit their addiction centre
  - To register an address (for example with a homeless centre)
  - To find out how to go to the probation office.

What are the lowest hanging grapes?

1. **Naloxone for every prisoners who have ever used opiates.**
2. Don't expect discharged prisoners to achieve too much on day 1. Just probation and one other. The other usually has to be accommodation.

Figure 3: Accommodation status for male prisoners upon release



51% or male and 48% of female prisoners did not knew where they will sleep at the time of their prison discharge

Reduce the need to see GP and or addiction service on day 1 of discharge.

- Give depot medication if possible
- Prescribed supervised methadone for one week
- Give 1 week of all other medication at discharge
- Use ROTL for everyone who has a chronic condition to arrange on-going care on the outside (such as community mental health, addiction, HIV clinic, Hepatitis C treatment)