PRISON REFORM TRUST

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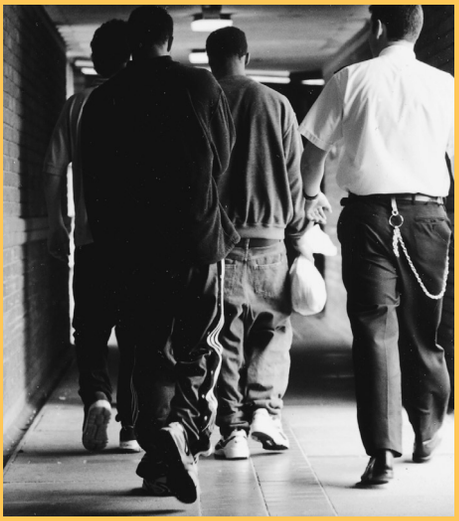
HIV and hepatitis in UK prisons:

addressing prisoners' healthcare needs

A report by the Prison Reform Trust and the National AIDS Trust



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Foreword

I am proud to write a foreword to this report. It makes a significant contribution to prison healthcare at an important moment.

For the past twenty years the care of prisoners' health has been a cause for concern and has attracted considerable criticism, including from successive Chief Inspectors of Prisons, from the British Medical Association and, most recently, from the Joint Committee on Human Rights in its Report of December 2004. During that time both the Prison Reform Trust and the National AIDS Trust have played their part in drawing attention to the need and the right of prisoners to better healthcare in general, and to the deficiencies in the healthcare response to prisoners living with or at risk of HIV in particular. As far back as 1988, the Prison Reform Trust published *HIV, AIDS and Prisons* calling attention to many of the issues which remain challenges today, while for several years the National AIDS Trust ran the National AIDS and Prisons Forum, bringing together those with expertise and responsibility for responding to HIV in the prison system.

Prison healthcare is in the process of transfer to the NHS and by April 2006 Primary Care Trusts will be responsible for commissioning health services in every publicly run prison in England and Wales. This represents a huge advance and an unprecedented opportunity to move towards the principle of equivalence so long advocated by all with an interest in the health both of prisoners and the public. Significant developments are also taking place in Scottish prison healthcare with the publication of the new Sexual Health Strategy and Draft Action Plan on hepatitis C.

In the field of HIV and hepatitis these are particularly timely developments, as the UK is facing a significant increase in new HIV and hepatitis diagnoses. Prisons are breeding grounds for blood-borne viruses because they bring together a population with disproportionate rates of high-risk behaviours in overcrowded and adverse conditions.

This report is the first of its kind. It is based on the findings of a survey of healthcare managers conducted jointly by PRT and NAT in prisons in England and Wales, and by NAT alone in prisons in Scotland and Northern Ireland. We are very grateful to the large number of healthcare managers and other prison staff who gave time and attention to answering the questionnaire.

The conclusions of the report are unequivocal: prisons' current policy and practice vary greatly between establishments and overall are failing to meet the needs of prisoners living with or at risk of HIV and other blood-borne viruses. Implementation of its recommendations would provide a firm basis for the development of a prison framework on HIV and hepatitis C which has been needed for so long.

Dame Ruth Runciman
National AIDS Trust Chair
Prison Reform Trust Deputy Chair

Executive Summary

There are significantly higher rates of HIV and hepatitis C in UK prisons than in the general population. Many prisoners are at particular risk, not only because of injecting drug misuse prior to prison, but also because of the risks of transmission inherent in prison, such as sharing needles and unprotected sex.

Prisoners are entitled to an equivalent standard of healthcare to the general population, including health promotion, disease prevention and treatment. The survey of UK prisons conducted by the Prison Reform Trust and the National AIDS Trust reveals that prisoners have received inadequate healthcare in relation to both HIV and hepatitis C, with grave consequences for their own health and, more generally, for public health through an increased risk of onward transmission.

The Prison Service and Prison Health have deployed measures intended to minimise the risk of transmission of blood-borne viruses. But the disciplinary role of the prison setting has imposed serious limitations on the extent to which healthcare can implement an equivalent service for prisoners. This report sets out how a harm minimisation approach would inform work in responding to injecting drug use, unprotected sex, raising awareness through education, and treatment.

Education and Information

There is evidence of significant levels of undiagnosed infection of both HIV and hepatitis C in prisons. This clearly has serious consequences for the health of the undiagnosed prisoners and for risks of onward transmission. PRT/NAT recommends regular anonymous serosurveys of prisoners and suggests that Prison Health should conduct one within the next 12 months.

The PRT/NAT survey reveals dissatisfaction among both staff and prisoners with the information and training currently available. More must be done to provide effective information to prisoners on HIV and hepatitis C, and on the availability and advantage of testing, with assurance of confidentiality. At present confidentiality is too often broken or compromised, with devastating results for the prisoners concerned.

Prison staff, and in particular healthcare staff, should be trained in the identification of risk behaviours and possible symptoms of HIV or hepatitis infection in order to offer tests promptly, sensitively and appropriately. All uniformed and healthcare staff must also receive equality training to end stigma and discrimination around sexual orientation, race and HIV/hepatitis C status.

Harm minimisation

Although illegal, injecting drug use takes place in prisons and can involve the sharing of needles. This practice carries a high risk of HIV and hepatitis C infection. Harm minimisation measures to reduce the risk of infection are, however, widely misunderstood and are inconsistently provided or are not available at all. As a matter of urgency, those responsible for the health of prisoners in the UK should ensure that:

- methadone maintenance therapy is available to all who need and wish it
- mandatory drug testing, which is ineffective in discouraging opiate misuse, is vastly scaled down
- disinfecting tablets for injecting equipment are universally and confidentially available
- a pilot programme is established to investigate the feasibility of a needle exchange programme in prison
- there is comprehensive education for relevant staff and at risk prisoners on harm reduction around injecting drug use.

Infection can also take place in prison through unprotected sex. There is currently no guarantee of access to condoms. The PRT/NAT survey and evidence provided by prisoners reveal the level of difficulty and bureaucratic obstacles that many face if they wish to protect their health and that of sexual partners through condom use. Condoms and lubricant must be made freely and confidentially accessible to all prisoners.

Treatment

The PRT/NAT survey and statements by individual prisoners reveal how breaches of confidentiality can compromise effective treatment. There are also problems resulting from lack of medical expertise, inadequate facilities and the frequent moving of prisoners between prison establishments. Obvious inadequacies in treatment also act as a disincentive to test.

Rolling out best practice

The PRT/NAT survey also found many individual instances of good practice, for example, the involvement, in almost half of the prisons, of local GUM clinics. In pockets, local agencies are working together to ensure that people in prison have access to services and that treatment is integrated so that it can continue after prison. These examples must be rolled out to become standard practice across the prison system. Every prison should have a clear policy on HIV and hepatitis C. An agreed framework of best practice for prevention, treatment and care in relation to HIV and hepatitis C, based on the principles of harm minimisation, should be applied in all places of detention in the United Kingdom.

1. Background

This report examines prisoners' healthcare needs in relation to HIV and hepatitis C in UK prisons. It is being published at a time of a radical transformation in healthcare in prisons in England and Wales, as responsibility is being transferred in the case of public prisons from the Prison Service to Primary Care Trusts (PCTs). Significant developments are also taking place in Scottish prison healthcare with the publication of the new Sexual Health Strategy and Draft Action Plan on Hepatitis C.

The report is informed by the findings of a survey sent to healthcare managers in all establishments across the UK, jointly conducted from November 2004 to January 2005 by the Prison Reform Trust (PRT) and the National AIDS Trust (NAT) in England and Wales, and by NAT alone in Scotland and Northern Ireland.

PRT is an independent charity, which works to create a just, effective and humane penal system. It inquires into the system, informs prisoners, staff and the wider public, and seeks to influence Government towards reform.

Through contact with prison healthcare managers, officials, and prisoners, PRT was alerted to causes for concern about the risks of transmission of HIV and hepatitis between prisoners.

PRT made arrangements to collaborate with NAT in order to draw upon its expertise in HIV. The collaboration has sharpened the analysis of the data gathered during the course of the project, enhancing both the quality of the study and the efficiency with which the work has been carried out. The project has involved joint drafting of the questionnaire, shared responsibilities for analysing the data, and combined work in preparing the report.

NAT is the UK's leading independent policy and campaigning charity on HIV and AIDS. The organisation's aims are to prevent the spread of HIV; ensure people living with HIV have access to treatment and care; and eradicate HIV-related stigma and discrimination. NAT's involvement in this project serves these aims and will contribute to the organisation's development of a Framework for HIV and hepatitis services in prisons.

The aims of the survey were to:

- Collate information about the measures currently adopted in prison establishments in the UK to prevent the spread of HIV and hepatitis and the nature of treatment provided
- Gather examples of good practice in the prevention, testing and treatment of HIV and hepatitis, and to identify gaps and barriers in these areas
- Promote improvements in healthcare and address key HIV-related issues such as discrimination and education.

Sixty-three completed surveys were received from the 139 prisons in England and Wales and 11 from the 16 prisons in Scotland. The Northern Ireland Prison Service (NIPS) also returned the survey.

PRT and NAT also conducted focus groups in three selected prisons in England, and sent individual questionnaires to be completed by HIV-positive prisoners in establishments holding people living with HIV. Seven completed questionnaires were returned. PRT and NAT held consultative meetings with officials from Prison Health.

Finally NAT held meetings with two organisations involved in HIV-related prison work, Positively Women and +Ve.

PRT and NAT will argue that the risks of HIV and hepatitis C in prison are increasing. People who are sent to prison have a right to expect that the state will protect their wellbeing. Thus far, prisons and prison healthcare have failed to meet the needs of prisoners or do enough to prevent the transmission of these illnesses. With regard to viral hepatitis, this report focuses primarily on hepatitis C, though it includes, where relevant, some information about hepatitis B.

2. Principles of healthcare guiding this study

The approach taken in this study is guided by two principles of healthcare: equivalence, which relates the standard of healthcare in prison to that available outside; and harm minimisation. The findings will be considered in light of these principles, detailed below.

Equivalence

The principle of equivalence holds that prisoners should receive standards of care and treatment equivalent to those accessible to the general public. The principle is stated in key international documents such as the WHO Guidelines on HIV Infection and AIDS in Prisons (1993).

The Prison Service policy documents on healthcare and services in prison acknowledge the principle of equivalence. For example:

Standards: Health Services for Prisoners (May 2004)

> "To provide prisoners with access to the same range and quality of services as the general public receives from the National Health Service (NHS)".

Note that the Standards cover communicable disease prevention and control, i.e. establishments should have effective arrangements for the prevention, control and management of communicable diseases.

Prison Service Order 3200: Health Promotion (2003)

> "The Prison Service in partnership with the NHS has a responsibility to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the NHS. This means that prisons should already provide health education, patient education, prevention and other health promotion interventions within that general context".

Health Promoting Prisons: a shared approach – A strategy for promoting health in prisons in England and Wales, March 2002

> "Prisoners should be provided with a broadly equivalent range and quality of services, based on assessed need, as the general public receive from the NHS".

Harm minimisation

Harm minimisation is a response to drug misuse intended to decrease the adverse social and physical effects of drug-taking, without necessarily demanding abstinence. It is about working with the patient to find ways of reducing the risks of drug-taking behaviour, while acknowledging that they are likely to continue to take drugs. In the prison context, practising harm minimisation is inevitably complicated by the dominance of a punitive response to drug misuse.

Key features of harm minimisation policies in relation to drug misuse include:

- Priority assigned to reducing the negative health consequences of drug misuse
- Service User Involvement, empowering drug misusers to take personal responsibility for reducing the risks of their drug-taking behaviour
- Acceptance that drug misuse occurs and focus on safer behaviour rather than coerced abstinence
- Quality of life – not drug misuse cessation – is the key measure of success.

Consensual sex, which also carries the risk of transmitting HIV, hepatitis and other STIs, might equally be managed with a harm minimisation approach rather than a disciplinary one.

HIV/AIDS and human rights: international guidelines

In addition to the two principles outlined above, it is important to be aware of the international guidelines on HIV/AIDS and Human Rights produced by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and the Joint United Nations programme on HIV/AIDS (UNAIDS). Guideline 4 on 'Criminal Law and Correctional Systems' declares that 'States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted at vulnerable groups'.

The guidelines go on at paragraph 29(e) to explain their application to prison systems:

> "Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation of HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered".[1]

[1] HIV/AIDS and Human Rights International Guidelines OHCHR and UNAIDS 2004

3. Prisoners' health: whose responsibility?

England

The Prison Service was formerly responsible for prison healthcare. But following the recent development of a partnership with the NHS, responsibility for ensuring that prisoners receive adequate healthcare will lie with the Department of Health. Responsibility for the commissioning of health services in prison is being transferred, in three phases from 2004-2006, to the local Primary Care Trusts (PCTs). By April 2006, local PCTs will hold responsibility for healthcare in all publicly run prisons in England. However, general health services in the privately contracted prisons in England are part of the overall contract with the Home Office, and arrangements vary.

The transfer means that prisoners are to be treated as temporary residents of the PCT in which the prison is located. The hallmark of the change is to describe the people under the responsibility of prison healthcare as patients not prisoners[2]. PCTs are responsible for commissioning prison health services and, at least for the next three years, can provide these services themselves[3]. Each PCT has to agree the specifications and arrangements with the governor of each prison. The prison governors facilitate the delivery of healthcare within their establishments and they continue to be accountable for clinical governance.

The transfer of responsibilities is very likely to bring significant challenges. Its impact will depend on the priority given to prison health and the funds allocated, but also on the extent to which the PCTs can achieve healthcare in prisons equivalent to that provided in the general community. The transfer also means that NHS providers will have to develop their understanding of the cultural norms of the prison environment in order to respond to prisoners' needs whilst adapting their services, care and support to the prison regime and its operational constraints. However, even in prison, healthcare staff should treat prisoners as patients and provide the same standard of care as that provided to patients in the general community. In turn, the prison will need to grapple with new concepts such as patient choice and involvement.

Wales, Scotland, and Northern Ireland

Healthcare services in Wales's four prisons are funded by the National Assembly for Wales, and are commissioned by the four local health boards in which the prisons are located: Cardiff, Swansea, Bridgend and Monmouthshire.

In Scotland, the responsibility for healthcare in prisons remains with the Scottish Prison Service, an independent agency working closely with the Scottish Executive.

Healthcare services in Northern Ireland's three prisons are jointly funded and commissioned by the Department of Health, Social Services & Public Safety and the Northern Ireland Prison Service. Commissioning of health services in Northern Ireland prisons is through a range of contracts with Health Service providers.

[2] The impetus for the change came from a Discussion Paper published by the Chief Inspector of Prisons, 'Patient or Prisoner? A new strategy for health care in prisons' (1996).

[3] The Government White Paper 'Commissioning a Patient-Led NHS' suggests that from the end of 2008 PCTs will be limited to a commissioning function. See the Conclusion of this briefing paper.

4. HIV and Hepatitis C in the UK

There are significantly higher rates of HIV and hepatitis C in prisons than in the general population.

HIV in UK prisons

Across the world, rates of HIV are higher in prisons than amongst the wider population, and the UK is no exception. In 1997 the Department of Health conducted an anonymous serosurvey of HIV in prisons in England and Wales. The survey established that there was a prevalence of 0.3 per cent amongst adult male prisoners and 1.2 per cent amongst adult female prisoners[4]. A survey in Scottish prisons also in 1997 found HIV prevalence of 0.3 per cent amongst adult male prisoners and 0.6 per cent amongst adult women prisoners[5].

As can be seen from the table below of 2003 HIV prevalence rates, even if these 1997 prison prevalence rates have remained unchanged, they would continue to be significantly higher than those of the UK population generally. But given the significant increases in HIV prevalence since 1997 (new diagnoses are now at over 7,000 a year, compared with 2,750 in 1997), it could well be the case that prison prevalence rates are now higher than those recorded eight years ago.

Table: HIV Prevalence rates in the UK 2003 (source: Health Protection Agency)

Nation(s)	No. PLWH	Prevalence rate	Prevalence men	Prevalence women
England and Wales	50,000	0.096%	0.13%	0.055%
Scotland	2,600	0.043%	0.063%	0.031%
N Ireland	260	0.015%	-	-

Hepatitis C in UK prisons

The Hepatitis C Action Plan for England (2004) estimates the numbers in England chronically infected with hepatitis C as approximately 200,000, or 0.4 per cent of the population.[6] Others question this figure, citing estimates made by hepatologists as high as 500,000. The Hepatitis C proposed Action Plan in Scotland (2005) provides estimates of prevalence for 2004 at 37,500 chronically infected or 0.7 per cent of the population.[7]

Only 38,000 of those infected by hepatitis C in England are diagnosed and according to a recent report by the Hepatitis C Trust the UK diagnoses and treats a far lower proportion of those with hepatitis C than France, Germany, Italy or Spain. Early diagnosis and treatment can cure between 60 per cent and 80 per cent of those treated. Without diagnosis and treatment, about a third of those infected with chronic hepatitis C will go on to develop serious liver disease, which can prove fatal without a liver transplant. In addition, those undiagnosed are not able to make the lifestyle decisions which could reduce liver damage and prevent further onward transmission of the virus.

It is also the case that hepatitis C rates are higher in prisons than in the general population. The same anonymous serosurvey in England and Wales cited above found that the prevalence of hepatitis C was nine per cent amongst adult male prisoners and 11 per cent amongst adult female prisoners.

[4] 'Prevalence of HIV in England and Wales 1997' para.33 Department of Health 1998; see also Weild, Gill et al 'Prevalence of HIV, hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey' Communicable Disease and Public Health Vol 3 No 2 June 2000

[5] Scottish Prison Service Nursing Service Review 2003 section 2.6 www.sps.gov.uk

[6] Hepatitis C Action Plan for England para.1.1 July 2004 Department of Health

[7] Hepatitis C Proposed Action Plan for Scotland 2005 Scottish Executive p.14

Such higher prevalence rates are replicated in a survey in Scottish prisons which found a prevalence of eight per cent amongst adult male prisoners and 14.8 per cent amongst adult female prisoners. The Scottish prison population on 4 November 2005 was 6,899.

The true prevalence of hepatitis C in Northern Ireland is unknown, but it is estimated that it could be around 4,000 cases. A recent study reported a prevalence of hepatitis C of 1.06 per cent amongst prisoners who took part in the survey and no incidence of HIV[8]. The prison population in Northern Ireland on 7 November 2005 was 1,354.

In 1997, the prison population in England and Wales was 60,131. On 4 November 2005, it was 77,752, an increase of 29 per cent since May 1997. Even if the proportion of people who have HIV or hepatitis C when they enter prison remained the same, the number of prisoners with these blood-borne diseases would have increased by just under one third between 1997 and today. This by itself represents a significantly increased burden of care for the Prison Service. And, as has been shown, it may well be the case that prison prevalence rates are now higher than they were in 1997.

There are no available estimates of the numbers in prison co-infected with both HIV and hepatitis C. Co-infection can result in faster progression of liver disease and also has implications for anti-retroviral treatment regimes and possible side effects. There is every likelihood that significant numbers of prisoners are co-infected, whether diagnosed or not, and in need of specialist care.

HIV and hepatitis C prevalence and the nature of the prison population

The significantly higher prevalence of HIV and hepatitis C in prison can be explained by the nature of the prison population and the risks of transmission specific to the prison environment. Prisoners represent a segment of the population that is at high risk of hepatitis C and HIV infection even before imprisonment. One of the main reasons for this is the high proportion of injecting drug users in prison. Over 90 per cent of hepatitis C infections are through injecting drug use. The Hepatitis C Strategy for England (2002) cites a study which reported that 29 per cent of women prisoners, 24 per cent of men in prison and four per cent of young offenders had injected drugs at some point in their lives. One study has estimated that among sentenced prisoners who are injecting drug users (IDUs) in England and Wales[9], 30 per cent have hepatitis C and 20 per cent hepatitis B.

In the UK, the two main groups affected by HIV are men who have sex with men and black Africans. IDUs are only a small proportion of those living with HIV in the UK. Only 6.5 per cent of all HIV diagnoses reported in the UK to the end of 2003 had probably been acquired through injecting drug use.[10] HIV prevalence amongst IDUs attending specialist services is 0.5 per cent in England, Wales and Northern Ireland, and 0.4 per cent in Scotland, but 2.9 per cent in London. These rates are, however, significantly above general population HIV prevalence rates and have important implications for prisons given the large proportion of those imprisoned who have been IDUs.

Recent significant increases in the black African prison population could also have increased HIV prevalence in prison. There are 16,200 black African men and women living with HIV in the UK, 31 per cent of the total number of those living with HIV and the largest group affected by HIV through heterosexual sex. In 2000, the population of white prisoners represented 188 per 100,000 in the general population. In the same year, the rate for black prisoners was 1,615 and black Africans in particular were incarcerated at a rate of 1,704 per 100,000[11].

[8] Department of Health, Social Services and Public Safety, Hepatitis C, Hepatitis B and HIV in Northern Ireland Prisons: A cross-sectional survey, Northern Ireland, 2004.

[9] King's College London, International Centre for Prison Studies, Prison Health and Public Health: The Integration of Prison Health Services – Report from conference, April 2004.

[10] Health Protection Agency 'Focus on Prevention' p.52 2004

[11] Commission for Racial Equality (2003) Racial Equality in Prisons: A formal investigation by the Commission for Racial Equality into HM Prison Service of England and Wales, Pt 2, London: Commission for Racial Equality, p. 27.

It is clear from past serosurveys and the nature of the prison population that there are higher prevalence rates of both HIV and, in particular, hepatitis C in UK prisons. Regular anonymous serosurveys should be carried out across prisons in the UK to assess trends in HIV and hepatitis C infection, and in HIV/hepatitis C co-infection. The higher prevalence rates underline the urgent need to improve the prevention and treatment of these two conditions. The next two sections of this report examine the high risk behaviours amongst prisoners, in particular injecting drug use and unprotected sex, which must be addressed to prevent onward transmissions of these viruses in prison settings.

5. Drug misuse, HIV and hepatitis C, and preventative strategies in prison

Injecting drug use in prisons in England and Wales

Recent research by the Office for National Statistics and National Addiction Centre (SSD/NAC)[12] has produced useful information about patterns of drug misuse in prisons. About one in five prisoners reported having used heroin at some time while in prison. However, for all types of illicit drugs, prisoners reported much lower levels of misuse in prison than outside: for cannabis from 51 per cent outside to 19 per cent inside prison, and for opiates from 30 per cent to 14 per cent. [13]

Of particular interest for this report, SSD/NAC found that drug misusers were far less likely to inject heroin in prison. Only one per cent said that they had injected in prison, whereas 18 per cent said that they had injected drugs in the month before coming to prison. A previous study had suggested that 6.7 per cent of prisoners injected drugs and that there was a high level of needle sharing by prisoners who used drugs intravenously.[14] A Home Office report suggested that two per cent of prisoners inject drugs in prison, but acknowledged that there may be significant underreporting of the problem because of the stigma and illegality of drug misuse in prison.[15]

Different estimates about the extent of injecting can be explained in part by the significant variations in drug misuse patterns in different types of prison. For example, in the SSD/NAC study, two per cent of the prisoners in young offender institutions had misused heroin at some time in prison, in contrast to 32 per cent of men in training prisons[16] and 17 per cent of women. Men in local prisons were twice as likely to have misused cannabis in the previous month as heroin (25 per cent to 13 per cent), while women were almost twice as likely to have misused heroin as cannabis in the past month (11 per cent to six per cent)[17]. These contrasts suggest that though it is possible that the proportion of all prisoners who inject in prison could be as low as one per cent, the rate of one particular group (for example, women or remanded adult men) could be much higher.

A former prisoner told +Ve:

> "Sometimes the needle gets rinsed in a bowl of water after being used, but that doesn't do much. Other times it's just passed from girl to girl. I mean, if you want a hit and you want it bad, you are not going to stop everything and clean your needle (…) I don't think I was positive when I went inside. But when I came out and started going to rehab they talked to me and advised me that it may be worthwhile getting a test. I agreed, thinking it would be negative and would give me peace of mind. I can be such a stupid cow."
> (Paula)[18]

Injecting drug use in prison involving the sharing of needles carries significant risk of transmission of HIV as well as hepatitis B and C. For hepatitis C, there are risks, not only in sharing needles, but also foil, spoons, and other injecting paraphernalia, because even a microscopic amount of blood can transmit the disease. Unlike the outside community, where needles are more readily available, in prison the possession of a needle is a punishable offence. For this and other reasons the prison environment increases the chances that drug misusers who inject in prison will share needles.

[12] SSD/NAC: Social Survey Division (Office for National Statistics) and National Addiction Centre, The impact of mandatory drug testing in prisons, by Nicola Singleton, et al., Home Office Online Report 03/05, 2005, page 11.
[13] Ibid, p. xv.
[14] R. Swann, and P. James, The effect of the prison environment upon prisoner drug taking, The Howard Journal of Criminal Justice, 1998, Vol. 37(3), pp. 252-265.
[15] Home Office Research, Development and Statistics Directorate, Prisoners' drug use and treatment: seven research studies, July 2003.
[16] SSD/NAC: 11. 'Training' prisons hold sentenced men, usually after an assessment at a local prison.
[17] SSD/NAC: 11.
[18] From +ve online, October 2000, Prisoner Cell Block HIV; online: www.howsthat.co.uk/00/10/001005.htm)

"When I went inside I had been positive for two years (…) It is so boring inside that I'm sure people do [drugs and sex] just to pass the time. I'd say most prisoners are on something. (…) The guards often turn a blind eye (…) We'd sit round, sort the gear out and then take it in turns to shoot up. The needle (made from an old biro) would be passed from one person to the next. The chances are, almost all of those men are now HIV-positive."
(Harry)[19]

Injecting drug use in prisons in Scotland and Northern Ireland

In 2000, there were an estimated 23,000 IDUs in Scotland[20] and about half of those had hepatitis C. It has also been suggested that one in five prisoners in Scotland may have hepatitis C.[21]

A Scottish study in Glenochil prison provided definitive evidence that outbreaks of HIV infection can occur among incarcerated populations because of injecting drug use[22]. Of 29 prisoners who had reported injecting in Glenochil and who were then tested, 14 were found to be HIV positive. Thirteen of them had a common strain of HIV which proved that they had been infected in prison.

The 2004 study among prisoners in Northern Ireland found that 11 per cent injected drugs.[23] It also found that one in five injectors started injecting while in prison. Almost 10 per cent of the injectors also reported sharing equipment while in prison.[24]

Mandatory drug testing (MDT)

England and Wales

The Prison Service has relied on a control-based and so-called "deterrent" approach to drug misuse in prison, especially via mandatory drug testing (MDT). Prisons in England and Wales test 5-10 per cent of their prisoners each month. Evidence suggests, however, that this policy does nothing to discourage injecting drug use. It is also a difficult context in which to pursue a harm minimisation approach.

The initial research on the impact of MDT suggested that though it appeared to inhibit prisoners from using cannabis, it was not as effective at detecting, or deterring, the misuse of heroin.[25] This is because smoked cannabis is traceable in urine much longer (up to one month) than drugs such as heroin and cocaine administered by injection.

The most recent evaluation of MDT (SSD/NAC, 2005) assessed the impact of random drug testing. In parallel with earlier studies, the SSD/NAC research found that MDT was less likely to detect heroin than cannabis misuse. MDT results seriously underestimate the prevalence of heroin misuse. For example, in their 1997 data set, 14 per cent of prisoners said that they had misused heroin, while only four percent had been detected by drug testing[26]. The research also concluded that MDT was not an effective means of directing drug-misusing prisoners to treatment.

SSD/NAC asked prisoners about their reasons for abstaining from drug misuse in prison. Focussing on what drug misusers believed were the main risks of using drugs, 70 per cent said the main risk for cannabis was 'detection/punishment', but this was true for only half as many about heroin. Over a quarter felt that health issues were the main risk of heroin misuse[27] . These comparisons suggest that education about the health risks of heroin use could be more effective than deterrence methods in inhibiting heroin use among prisoners.

[19] Ibid. [20] HPA, supra at 20. [21] Supra, at 6.
[22] See S. M. Gore et al, Drug injection and HIV prevalence in prisoners of Glenochil prison, British Medical Journal, 1995; 310:293-296 (available at www.bmj.com). For international evi ence, see Canadian HIV/AIDS Legal Network, Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Expertise, 2004 (available at www.aidslaw.ca).
[23] Supra, at 9.
[24] The report explicitly states that the results quoted should be treated as minimum estimates, as reliance on self-reported needle sharing behaviour is likely to produce an underestimate.
[25] Edgar and O'Donnell, Mandatory drug testing in prisons: the relationship between MDT and the level and nature of drug misuse, London: Home Office Research Study, 1998, No. 189.
[26] SSD/NAC: xiii.
[27] Supra, at 19, p. 84

Other research has been more critical of the coercive approach in prisons, with its neglect of rehabilitative methods of encouraging people to turn away from drug misuse. Research conducted in 1997 concluded that:[28]

> [t]he MDT process is counterproductive. It deflects attention from the real issue of the purposes and funding of the prison system. Drug testing also deflects attention from other crucial areas like the spread of HIV and AIDS in prison. MDT increases tension in prisons, appears to be encouraging a shift from 'soft' to 'hard' drugs, is adding to the workload of an already overburdened staff, is costing a lot of money that could be better spent and is failing to provide adequate treatment and follow-up procedures. It is, thus, primarily an indiscriminate punitive regime … [29]

Scotland and Northern Ireland

Scottish prisons test 10 per cent of their prisoners each month. SPS reported that 80 per cent of prisoners who admit injecting heroin say they share needles.[30] The Scottish Prison Service is currently undertaking a review of its drug testing procedures. This review includes the reasons drug tests occur as well as the methodology used. At this time, no firm decisions have been made as to the future of mandatory random drug testing in Scotland. There are plans to introduce mandatory drug testing in prison establishments in Northern Ireland.

Harm minimisation and injecting drug use

Harm minimisation is an essential response to injecting drug use in prisons if there is to be a reduction in transmission of HIV and hepatitis. Recent government documents on hepatitis C outline key elements of the harm minimisation approach (see for example 'Hepatitis C Strategy for England' August 2002 Department of Health; 'Hepatitis C Action Plan for England' July 2004 Department of Health; 'Hepatitis C Proposed Action Plan for Scotland' June 2005 Scottish Executive; 'Strategic Framework and Action Plan for the Prevention and Control of Hepatitis C in Northern Ireland 2004-07').

Methadone treatment programmes

The HM Prison Service drug strategy sets out key points of a harm minimisation strategy, which include the management of symptoms of withdrawal in line with the Department of Health guidelines, rehabilitation programmes and therapeutic communities. However, as the PRT/NAT survey shows, not all prisons offer these services.[31]

Substitution treatment programmes, including methadone maintenance, have been shown to benefit drug-dependent prisoners, in particular by reducing their frequency of injecting.[32] Methadone maintenance therapy (MMT) is an essential component of a comprehensive harm minimisation approach. For those willing to stop injecting heroin, methadone blocks opiate withdrawal symptoms. Forty-three per cent of the prisons in England and Wales responding to the PRT/NAT survey said that they provided maintenance prescribing for opiate dependency. This is welcome as far as it goes but MMT should be made available throughout the prison system.

Methadone maintenance therapy cannot, however, be considered an adequate substitute for needle exchange. There are often issues of the capacity of MMT programmes to meet demand. Moreover, prisoners may continue to inject drugs even while on MMT and MMT is not appropriate for occasional or recreational users who inject opiates. [33]

[28] M. MacDonald, "Mandatory Drug Testing in Prisons", University of Central England in Birmingham, January 1997.
[29] Ibid.
[30] Prison drug tests "failing to have impact", The Scotsman, 22 April 2005 (http://thescotsman.scotsman.com/index.cfm?id=428522005)
[31] See M. MacDonald and D. Berto, Harm Reduction in Italian and UK Prisons: The Gap Between Policy and Implementation for HIV and Drugs, Paper presented at the 13th International Conference on the Reduction of Drug Related Harm, Ljubljana, Slovenia, 3-7 March 2002.
[32] See WHO, UNAIDS and UN Office on Drugs and Crime, Evidence for action on HIV/AIDS and injecting drug use – Policy Brief: Reduction of HIV Transmission in Prisons, 2004.
[33] See 'Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience' Canadian HIV/AIDS Legal Network 2004

Disinfecting tablets in prison

Disinfecting tablets were introduced in English prisons in 1995 but quickly withdrawn upon advice from the Department of Health. A pilot project was then conducted in 1998 in 11 Prison Service establishments but never extended to all prisons in England and Wales. Prison Service Instruction 53/2003 provides that tablets for disinfecting shared needles and syringes were to be made available to prisoners from 1 April 2004. Due to unexpected preparatory work, the re-introduction of disinfecting tablets has taken longer than planned and therefore they are not currently available in all establishments. Only eight out of the 61 English and Welsh prisons which responded to this question in the PRT/NAT survey said that disinfecting tablets were available.

Prisons in Scotland and Northern Ireland have pursued markedly different approaches. Disinfecting tablets were introduced in Scottish prisons in December 1993. In contrast, in Northern Ireland, they are not available.

A key element to the use of disinfecting tablets by prisoners is the provision of adequate information on how to use them, including drawings for prisoners who cannot read.

As is the case with MMT, whilst disinfecting tablets are an essential aspect of harm minimisation, medical literature suggests that they are not fully effective in destroying all blood-borne viruses present in used needles. As a result, they should not be used as a substitute for sterile needles.

This view is shared by the Department of Health. When the re-introduction of cleansing tablets was announced, a DH spokesperson stated that cleansing tablets were not the best way to protect against the transmission of diseases:

> "[We would not encourage the introduction of cleansing tablets] as being as effective as the issuing of sterile needles. We don't recommend it. We regard the needle exchange programmes in place throughout the whole of the [health] system as the most effective way of reducing blood-borne diseases." [34]

Needle exchange programmes

Evidence demonstrates that the most effective measure for preventing transmission of hepatitis C and HIV among injecting drug users is the use of sterile needles and syringes. A number of studies suggest that disinfection is less effective at preventing the transmission of hepatitis. Needle exchange programmes are widely available throughout the UK as a key harm minimisation intervention for IDUs. Nevertheless, none of the prison services in the UK has plans to introduce needle exchange schemes in prisons.

The policy on needle exchange schemes was recently challenged by a prisoner. Judicial review proceedings against the Home Secretary were started in November 2004 for the government's failure to introduce needle exchanges in prisons, or even to conduct a trial into the practice. So far the case has not been successful. The judge refused permission for the case to continue and a renewed application heard at the Royal Courts of Justice (Administrative Court) in April 2005 was also dismissed[35]. The judge was satisfied that the Home Office clearly showed that it had considered the issues and that it was within its discretion to consider that needle exchanges should not be introduced. The judge put significant weight on security concerns (i.e. assaults by prisoners on other prisoners or prison officers) despite the fact that the Home Office produced no evidence for this and did not really refer to the matter in its arguments.[36]

[34] Health officials and Prison Service clash over HIV-prevention scheme, the Guardian, 1/03/2004.

[35] John Shelley v. The Secretary of State for the Home Department.

[36] It is uncertain whether the case will go to the Court of Appeal due to funding issues. If the case goes to the Court of Appeal and is allowed to continue and is successful, it would mean that the Home Office would have to take harm reduction measures in prison a step further, for example by introducing pilot programs.

It is apparent that, in practice, the harm minimisation interventions available in prisons are far from equivalent to those available in the general community.

Needle exchange policies in other countries

Needle exchange programmes have been operating in various prisons in Western Europe and Central Asia (Switzerland, Germany, Spain, Moldova, Kyrgystan, Belarus) and other countries are also looking into introducing them (Italy, Portugal, Greece).[37]

A comprehensive study by the Canadian HIV/AIDS Legal Network on international practice in prisons confirmed that needle exchange programmes are an effective harm-reduction measure against HIV and hepatitis C transmission in prisons. In particular, the report highlights that these programmes:

- Do not endanger staff or prisoner safety, and in fact make prisons safer places to live and work
- Do not increase drug consumption or injecting
- Reduce risk behaviour and disease (including HIV and hepatitis C) transmission
- Have other positive outcomes for the health of prisoners
- Have been effective in a wide range of prisons
- Have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons. [38]

There are a number of models for needle exchange in prison, including hand-to-hand distribution by prison medical staff, hand-to-hand distribution by peer outreach workers, hand-to-hand distribution by external NGOs or health professionals, and automated dispensing machines. There is evidence of success for all these methods in reducing syringe sharing in prisons. Other positive outcomes include significant reduction in heroin overdoses, a decrease in abscesses and other injection-related infections, and an improved environment in which to counsel injecting drug users.[39]

In Spain, the first pilot project started in August 1997. An evaluation undertaken after 22 months showed positive results and, as a result, in June 2001, the Directorate General for Prisons ordered that needle exchange programmes be implemented in all prisons. As of early 2004, exchanges were operating in more than 30 prisons, and a pilot programme had also been established in a prison in the autonomous region of Catalonia. [40]

The PRT/NAT survey findings on harm minimisation in prisons in England and Wales

The survey asked healthcare managers to what extent they believed their practices matched a harm minimisation approach in working with prisoners identified as high risk. The open nature of the question evoked a wide range of answers.

Sixteen of the 63 prisons (just over one quarter) each cited at least one example of harm minimisation. Before reviewing these, it should be said that the fact that these prisons implement some form of harm minimisation demonstrates to the others that it is possible.

The constructive examples of harm minimisation methods currently in use in prisons were broad-ranging, and not limited to the provision of disinfectants for cleaning needles. Education in risk management, for example, was cited as an example of harm minimisation, because it could lead a prisoner who was engaging in high-risk behaviour to modify their routines. Thus, in reporting on good practice in this area, we have included responses that might fall outside a

[37] Canadian HIV/AIDS Legal Network and "Lawyers Collective" HIV/AIDS UNIT, Prisoners' Health & Human Rights in the HIV/AIDS Epidemic, 2004.
[38] Supra at 27.
[39] 'Prison Needle Exchange: Lessons from a Comprehensive review of International Evidence and Experience' Canadian HIV/AIDS Legal Network 2004
[40] Canadian HIV/AIDS Legal Network, HIV/AIDS in Prisons Fact Sheet, 2004/2005, Prevention: Sterile Needles.

narrow understanding of the term, but which, nonetheless, worked with prisoners to reduce the adverse health effects of drug misuse and other high-risk behaviour. Here are the main examples of good practice:

- Helping prisoners to access services
- Enabling nurses to put into practice a non-judgemental attitude
- Providing education regarding needles
- Through the CARAT [Counselling, Assessment, Referral Advice and Throughcare] team, a one-day harm minimisation course
- Raising harm minimisation awareness on induction
- Actively encouraging vaccination for Hepatitis B
- Fostering a whole-prison approach
- Health promotion and free and easy access to a healthcare centre
- Health adviser in the sexual health clinic
- Prisoner involvement in health promotion for World AIDS Day
- Substance misuse team runs harm minimisation groups.

As has already been discussed, some specific areas in which harm minimisation can be developed further within current policy constraints are drug use advice, methadone maintenance therapy and disinfecting materials for cleaning needles.

Whilst a quarter of the prisons cited at least one example of harm minimisation, one in five (13/63) did not cite a single example of a harm minimisation measure; of those, two are particularly revealing:

> "There are problems when trying to negotiate around security."

> "[It's] very difficult [to implement harm reduction] without a needle exchange or to implement some comparable structures evident in the wider community."

There was also a second group of responses to this question (also 13/63 or 20 per cent) which interpreted harm minimisation in terms of precautions staff had to take to ensure that they were not infected with hepatitis or HIV, with little or no attempt to work with the drug misuser:

> "Appropriate prophylactic measures are always observed when dealing with HIV patient, e.g., double gloves."

> "A notice to staff is sent out annually focusing on 'universal precautions', informing staff of the need to handle all prisoners the same."

> "All staff aware of protocols in place. Freely available gloves. Maintain policy of treating all as high risks."

Although some of these responses suggest a proper use of universal precautions, others imply a discriminatory approach to the treatment of prisoners with HIV and/or hepatitis. There is also no suggestion in these answers that the prison has made any attempt to work with drug misusing prisoners to develop awareness of lower risk behaviour.

6. The transmission of HIV and hepatitis B and C in prison through sexual activity and other risk-taking behaviour

Sexual activity in prisons

Although there is little evidence available on the extent of consensual sexual activity in prisons in the UK, it is generally acknowledged that consensual sex does take place among prisoners. A Home Office study conducted in 1994/5 indicated that between 1.6 and 3.4 per cent of their random sample of 1009 adult male prisoners reported having had sex with another man while in prison, and little use was made of condoms[41]. Prisoners may not wish to disclose their sexuality or sexual activity, given the presumed illegality of sexual activity and the stigma attached to it.

Coercive sexual behaviour in prison is also largely under-reported. A recent study[42] found that two per cent of a sample of 208 prisoner participants had had forced penetrative sexual intercourse. In a population of approximately 75,000, this would equate to 1500 victims of forced penetrative sexual intercourse in a year. The author identified contributory factors including overcrowding, mental health problems of prisoners, and inadequate staff, the absence of suitable sexual or fulfilling relationships, the absence of conjugal visits, homophobia, general intolerance and the inability to fully exercise legal rights.[43]

When sex takes place in situations of intimidation and violence, there is a greater likelihood of tearing and bleeding, and the risk of HIV transmission is increased, especially for the victim but also the perpetrator. This is supported by extensive anecdotal evidence from prisoners and ex-prisoners, some of whom were HIV-positive before imprisonment, others who became infected after being raped in prison:

> "I was given a five minute chat and a few leaflets when I first when into prison (…) The first night I was in there I was raped by my cell mate (…) My bum was ripped. It kept bleeding. I was in agony going to the loo and I couldn't even sit down properly (…) Nobody spoke about rape inside, but you look at some of the guys and you know what's been going on (…). It wasn't until I got out and moved in with my girlfriend that I thought about things (…) Months down the line I went for an HIV test – it was positive."[44]
> (Tony)

More needs to be done by prison services to assess and respond to coercive sexual behaviour.

Prison Service regulations have sometimes been used against prisoners who engage in sexual activity. HM Prison Service has claimed that consensual sex in prison is illegal because prison cells are "public places". The current sexual offences legislation requires that sexual activity takes place "in private".

Attempts were made during the consultation on the sexual offences bill 2003[45] to argue that under section 74 of the bill - which covered the issue of "sexual activity in public" and provided a definition of "public place" – a prison cell is not a public place.

Section 74 reads that a "public place" is
a) a place to which the public or any section of the public has or is permitted to have access, whether on payment or otherwise, or
b) the common parts of a building containing two or more separate dwellings;

[41] Strang, J et al., (1998) HIV/AIDS risk behaviour among adult male prisoners, Home Office Research Findings 82.
[42] S. Banbury, "Coercive Sexual Behaviour in British Prisons as Reported by Adult Ex-Prisoners", The Howard Journal of Criminal Justice, May 2004, Vol. 43, No.2.
[43] Ibid.
[44] Prisoner interview with NAT.
[45] HL Bill 26 (as presented to Parliament on 28th January 2003).

It was suggested that a prison cell is not a place to which the public or any section of the public is permitted to have access. Prison officers cannot be considered members of the public as, while on duty, they hold the power of constable[46]. As for prisoners, although they could be considered members of the public, if the consenting prisoners took reasonable precautions to ensure privacy, then they would not be in breach of the law.[47]

The Prison Service's position on whether cells are public places has not been tested in court. However, this argument against the legitimacy of sexual activity between prisoners is unconvincing, particularly in the context of a failure to protect the health of prisoners who may otherwise resort to more risky sexual behaviour. If sexual activity is subject to punitive sanctions, or stigmatised, the likelihood is that people will be less likely to take precautions.

Policies relevant to sexual health in prison

The HM Prison Service policies on HIV and hepatitis (CI 30/1991; AIDS and HIV, 1990; and PSO 3845) acknowledge that sexual activity occurs in prisons. However, these policies deny the need for condoms. Prison Service documents also make references to nonoxynol-9 (N9) as adding additional protection when recent studies have revealed that N9 does not prevent HIV or STI transmission, but can instead increase risk of transmission.[48]

The Prison Service Healthcare Standard (May 2004) and the Prison Service Healthcare Standard (July 2002) which it replaced cited the principle of equivalence. Both standards discuss means of promoting health. However, the 2002 standard explicitly mentions HIV and other sexually transmitted illnesses in the context of health promotion. The 2004 standard does not; nor are HIV or STIs mentioned in the sections on the prevention and control of communicable diseases.

Section 3 of the Scottish sexual health strategy focuses on STIs and states that:

> if sexually transmitted infections are to be combated, action also needs to be taken on other factors, which are associated with the spread of disease. These include poor and inequitable access to clinical services including contraception and ineffective partner notification measures. There is a need also to tackle the incidence of sexually transmitted infections amongst high risk or socially excluded groups and those in prisons. [49]

Section 5 (Practical Plan for Action) includes an action to be taken by the Scottish Prison Service, to:

> sustain its commitment to health improvement and harm reduction enabling the availability of condoms for males and dental dams for females throughout the course of their detention in young offender institutions and adult prisons. [50]

Condom provision in prisons

In England and Wales, the policy guidance on condom provision is set out in the form of a letter to prison medical officers (the "Dear Doctor" letter)[51] which provides that condoms and lubricants should be prescribed, when in the doctor's judgment, there is a genuine risk of HIV transmission.

[46] Prison Act 1952.
[47] Submission by Steve Taylor, a writer on criminal justice and prison issues, and a specialist in this area.
[48] National AIDS Trust, The need to remove nonoxynol-9 (N-9) from condoms and lubricants, August 2004, available at www.nat.org.uk.
[49] Scottish Executive (2005) Respect and Responsibility' Strategy and Action Plan for Improving Sexual Health, online: http://www.scotland.gov.uk/Publications/2005/01/20603/51178, Section 3, paragraph 21.
[50] Ibid., Section 5: Practical Plan for Action.
[51] PDG (95) 324/16/18

Findings of the survey conducted by PRT and NAT highlight the limitations and uneven application of this policy:

- The guidance on condom prescription is not always implemented
- When available, prisoners are often inhibited from asking for condoms because of a lack of confidentiality
- when available, the process to obtain condoms may be very slow.

The guidance is not supported by a Prison Service order (PSO), which would prioritise implementation.[52] However, the Prison Service is currently preparing a PSO, expected to be published late summer/autumn 2005. It is uncertain whether this PSO will make a full commitment to the free and confidential provision of condoms in prison.

> "I was 25 when I was banged up. I was also on combination therapy (…) before I went to jail (…) After months of regular beatings (…) [t]his big, mean, menacing bloke has summoned me to his cell. He said he'd decided to take me under his wing (…) You can't say no - I wouldn't be here if I had. In the beginning we would have sex every day, sometimes three times a day (..). Now condoms are hard to come by in prison. As I went down to the medical quarters twice a day (to get my medication), I used to ask there. But I was rationed to one a day (…) I was told that if I took the dirty condom back – to prove it had been used – they would give me more (…) But even taking dirty condoms back didn't always guarantee fresh supplies (…) I doubt the authorities would admit it, but prisoners are constantly treated for sexually transmitted diseases. It goes on daily. If I hadn't gone in with HIV, I'd have been damned surprised if I hadn't come out with it."[53]
> (Dan)

In England, the high court judgment in R v. Secretary of State for the Home Department ex p. Fielding (1999)[54] reflected the inadequacies of current prison policy on condom provision. In this case, the judge ruled that a medical officer should only prescribe condoms for "genuine health reasons":

> "The mere fact that a person asserts that he wants a condom does not mean that he is a genuine homosexual, nor does it mean that he is intending to engage in penetrative or other dangerous sexual activity. Nor does it necessarily mean that he is in truth a consenting party to whatever activity is anticipated (…) It seems to me that whenever a prison medical officer is satisfied that a request for condoms is from a genuine homosexual who is intent on indulging in what would otherwise be unsafe sex, he should prescribe condoms."[55]

In its Prison Service review 1995, the AIDS Advisory Committee recommended that "condoms and lubricants should be made easily accessible to prisoners throughout their period of detention". Having to obtain condoms "on prescription" is obviously far from making them "easily accessible".

The PRT/NAT survey findings on policies about condoms in prisons

England and Wales

Healthcare managers in 30/47 prisons holding adult males (64 per cent) said that condoms were available. Condoms were also reported to be available in three-quarters of the young offender institutions responding and in half of the women's prisons. The survey did not ask detailed questions about how prisoners could obtain them and under what circumstances.

[52] A PSO is expected to be published in 2005
[53] Prisoner interview with NAT.
[54] CO/590/98, High Court of Justice, Queen's Bench Division, 1999
[55] Per Justice Latham

Policies on availability of condoms and lubricants highlight weaknesses in many prisons. For example, one prison which stated that condoms were available enclosed a copy of the relevant protocol. But the protocol leaves no doubt that condoms are available only "on prescription" and that the process to get a condom is far from straightforward

Three of the 22 prisons responding to the survey which do not supply condoms have a daily prison population of over 1,000; one of them has 1200 prisoners and reported six HIV-positive prisoners. Other prisons with a daily prison population of over 900 reported having no known HIV-positive prisoners, almost certainly an inaccurate assumption. Given the high probability of a number of HIV positive inmates in the larger prisons, it is a matter of great concern that some of these prisons do not provide condoms.

Letters to NAT from ex-prisoners and findings from the individual questionnaires received from HIV-positive prisoners provide evidence that the "official" figure of 64 per cent of prisons in which condoms are available overstates the number of prisons in which condoms are in fact accessible freely by prisoners.

An HIV-positive prisoner responded that they did not have access to condoms but condom availability was mentioned in the survey sent back from the prison at which that prisoner is currently incarcerated.

A gay HIV-positive prisoner who responded to the individual questionnaire said that although condoms are not available, he has sex frequently and uses surgical gloves.

One HIV positive prisoner told NAT of an occasion when after some delay he had succeeded in getting a condom, only to find it was past its use-by date.

Scotland and Northern Ireland

The Scottish Prison Service (SPS) has recently announced that free condoms and dental dams are to be made available in every Scottish prison[56]. Seven of the 11 prison healthcare managers in Scotland who responded to the NAT survey said that condoms were available on application. Five said that they wish more were done in relation to the provision of condoms.

In the prisons of Northern Ireland, condoms are not available. The seroprevalence study 2004[57] found that high-risk sexual practices (e.g. unprotected anal intercourse) were reported by very few prisoners (but this may be an underestimate).

Violent Victimisation

Fights and assaults in prison are a potential factor in the transmission of hepatitis C. The risk of violence is heightened by environmental prison factors. The dangers of becoming a victim of theft, or being bullied may lead some prisoners to use force pre-emptively.

Official rates of prison assaults significantly under-estimate the extent of violent behaviour, because they are based only on incidents that come to the attention of staff. More reliable evidence is gathered by HM Chief Inspector of Prisons, through surveys of prisoners. These show wide variations in rates of assaults, even between prisons of the same type. One in ten men in local prisons told the Inspectorate that they had been assaulted. Among the open male prisons, the rate was two percent; it was five per cent in training prisons; and 13 per cent among young offenders.

[56] Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health, Scottish Executive, 2005.

[57] Northern Ireland Department of Health, Social Services and Public Safety.

Fights and assaults in which there are only bruises or bumps involve no risk of HIV transmission. However, when bleeding occurs, there may be a very low risk of transmitting HIV, but the risk is greater for hepatitis C. It is cause for concern that many prisoners could be exposed to an increased risk of hepatitis infection as a direct consequence of prison violence.

Tattooing

The sharing of tattooing equipment in prison carries significant risks of transmission of HIV and hepatitis. Strang, et al (1998) found that 11 per cent of their total sample, and a fifth of those who had ever been tattooed, had been tattooed while in prison. The fact that as many as one in ten men in prison have had a 'prison tattoo' suggests that the greatest risk of transmission of hepatitis C might be via tattooing.

In Ireland, a study[58] found that almost half of the prisoners surveyed were tattooed, and that a quarter of those (nearly 15 per cent of total study participants) had received a tattoo while incarcerated. The researchers found that prisoners who had a tattoo were more likely to have hepatitis C than those without a tattoo. They also concluded that those who had been tattooed in prison were more likely to test hepatitis C positive than those tattooed outside of prison.

In January 2005, Correctional Service Canada began a safer tattooing pilot programme in six federal prisons, one holding women and five holding men institutions. The pilot involves education for the tattooist and for clients, and safer tattooing practices involving state-of-the-art tattooing equipment and infection control procedures.[59]

[58] J. Long et.al., Hepatitis B, Hepatitis C and HIV in Irish Prisoners, Part II: Prevalence and risk in committal prisoners 1999, The Stationery Office, Dublin, 2000.

[59] 'Safer tattooing piloted in six federal prisons' HIV/AIDS Policy and Law review Vol 10 No 2 August 2005

7. Education and training

Prevention through education

The Government's programme for action to tackle health inequalities recognises that prison is an important setting for health promotion activities.[60] Promotion of good health should cover not only mental health and substance misuse but also sexual health. Furthermore, it should be equipping prisoners not just to remain healthy in the prison environment but to protect and improve their health and that of their sexual partners and families after their release. However, the PRT/NAT survey found high levels of dissatisfaction with current health education in prison, with resources inadequate even to protect prisoners from immediate risks around HIV and hepatitis C.

This situation directly breaches the principle of equivalence in healthcare, already referred to, as found in Prison Service order 3200, issued in 2003. In the context of promoting awareness of the risks of HIV and hepatitis C, this would imply that all prisons should ensure that information should be made available to prisoners on:

- The risks of transmission of HIV and hepatitis B and C
- Options for testing and diagnosis
- The availability of counselling
- The nature of treatment options.

Another relevant document, Health Promoting Prisons (2002), includes the aims of employing a whole prison approach, improving communication with prisoners, and monitoring health promotion.

The survey findings for England and Wales

In relation to the education of staff and prisoners on HIV, the survey found the following:

- 72 per cent said that they provided some educational materials on HIV
- 45 per cent said that they had information on HIV specifically for staff
- 58 per cent said that they had information on HIV specifically for prisoners
- 41 per cent said that they had other materials available on HIV.

In relation to education on hepatitis:

- 81 per cent said that they provided information about hepatitis
- 77 per cent said they provided other materials about hepatitis.

An effective programme of health education requires that all prisons ensure that prisoners and staff receive accurate and clear information about HIV and hepatitis. Bald statistics on information provision cannot of course answer such important questions as real levels of access, use of and understanding of the information, and availability of additional explanation. But even in advance of further research into such questions, these percentages suggest an urgent need for Prison Health to develop and disseminate educational materials about the risks of transmission of HIV and hepatitis.

The lack of adequate materials for education on HIV and hepatitis was strongly highlighted in the prisoners' responses to the individual questionnaires, in focus groups and in responses received from ex-prisoners.

60 'Tackling health inequalities' DH 2003 para.3.25

An ex-prisoner (gay and HIV-positive) who contacted NAT about this study said that he had been advised not to disclose his HIV status to his fellow prisoners and staff. He also said that no healthcare staff knew anything about HIV and that he had to teach the counsellor about HIV. No educational material or training was available for staff and there was a lot more knowledge about hepatitis C, HIV still being seen as a "gay-related disease".

Materials that were provided in many prisons include leaflets, NHS literature and audiovisual materials. Two prisons only were using professional manuals (i.e. CHASE pack and National AIDS Manual (NAM) training manual).

The healthcare managers in just over half of the prisons (33/63) said that they were dissatisfied with the literature and other materials available to them on the prevention of HIV and hepatitis.

Six of the 11 healthcare managers in Scotland reported not being satisfied with the HIV educational materials available.

Training

When asked about HIV-related training given to staff, 35/55 prisons said that they had some training available, although in most cases not HIV-specific. Some respondents assumed that staff knowing about universal precautions amounted to "HIV training". Twenty prisons said they did not have any training available.

Six of 11 prisons in Scotland reported that lead nurses complete a BBV course. Two other prisons reported other relevant courses.

Conclusions

Prisons are currently failing in their responsibilities to ensure that both prisoners and staff receive adequate information and education on HIV and hepatitis C. This increases the risk of onward transmission in prison, and of inadequate treatment of those living with HIV and hepatitis C. It is also a lost opportunity build on best practice and to promote good health, with serious consequences for society as a whole.

In all prisons in the United Kingdom there has to be appropriate information on HIV and hepatitis C, to a consistent standard, provided in an accessible way to all prisoners and staff. This must be complemented by training for all prison staff to ensure an understanding of risks of transmission, basic facts about both conditions, and a requirement to treat all living with HIV or hepatitis C with respect for their rights and privacy.

8. Testing, Treatment and Aftercare for HIV and hepatitis C

There are nationally agreed standards for the testing and treatment of HIV, in particular the BHIVA (British HIV Association) guidelines and the MedFASH(Medical Foundation for AIDS and Sexual Health) recommended standards[61] for NHS HIV services. The principle of equivalence requires prison establishments to provide care to these standards. The NHS also publishes 'Hepatitis C: essential information for professionals and guidance on testing'.[62] More detailed work will be required on standards of treatment and care for hepatitis C and HIV in prisons and their conformity with national standards. The survey asked some preliminary questions, concentrating on HIV, and the results outlined below demonstrate current service provision in prisons falls below acceptable levels.

Availability of testing in prisons in England and Wales

The availability and offer of a test for HIV or hepatitis C is obviously essential for diagnosis and effective treatment. Late diagnosis can severely limit the efficacy of available therapies. Testing is also an important intervention to reduce further onward transmission of these viruses. Given the significantly increased prevalence of HIV and hepatitis C in prisons and continuing high risk behaviours, it is extremely important that information on the availability of HIV and hepatitis C tests is offered to those in prison as part of their induction and that where there is evidence of high risk behaviours or, of course, possible symptoms of infection the test should be offered. The testing process must be to the highest clinical and ethical standards, available promptly when requested, and with an assurance of confidentiality.

HIV-testing is available in 97 per cent of the 63 prisons in England and Wales which responded to the survey.

- 42/63 stated that they offered testing routinely
- 12 stated that they did not offer HIV testing routinely
- 46 provided testing under certain criteria (e.g., when the patient was a declared drug misuser)
- 1 prison did not know if there were criteria; and 2 said this question was not relevant.

These were not mutually exclusive categories. Some prisons offered testing to all prisoners identified as problem drug users and provided testing for anyone who requested it. Only one of the 12 that did not offer testing on a routine basis was a local prison. The eleven other prisons in this group would all receive prisoners who had first spent time in other establishments.

The length of waiting times required for tests varied enormously, from one day to four months. About one in ten did not state the length of the wait for a test, and some of those found the question irrelevant. Of the remainder, the wait for an HIV test was two weeks or more in 32/56 prisons, and one of these stated that the delay could be as long as four months. The wait was one week or less in only 22/56 (39 per cent) of the prisons that provided testing and responded to the question about waiting times.

Point of care testing, with a diagnosis available in 15 minutes, is increasingly available in Genito-Urinary Medicine (GUM) clinics outside prisons. This makes these waiting times within prisons even more unacceptable.

Such delays are a disincentive to test. Moreover, long waiting times are problematic given both the high numbers of people receiving short sentences or held on remand, and the constant movement of sentenced prisoners due to pressures of overcrowding and the duty to hold remanded prisoners close to courts.

61 See for example MedFASH recommended standards for NHS HIV services Chapter 1 paras.46 to 48 'People in prison'.

62 'Hepatitis C: Essential information for professionals and guidance on testing' NHS December 2004

Prison healthcare staff did the testing in 24 prisons (38 per cent). A local GUM service did the testing in 14 prisons (22 per cent). In 16 prisons (25 per cent) testing was done by a combination of the prison staff and the GUM clinic.

The survey also asked about testing availability for hepatitis B, hepatitis C and other STIs:

- 61 prisons (95 per cent) offered hepatitis B testing (about half routinely; a third on request; and six under certain criteria)
- 60 prisons (94 per cent) offered testing for hepatitis C (44 per cent on a routine basis; just over one-third on request; and six according to certain criteria)
- 58 prisons (91 per cent) tested for sexually transmitted infections: (one quarter routinely; one third on request; and one quarter according to certain criteria).

Scotland and Northern Ireland

All Scottish prisons which responded to the survey said that HIV-testing was available, on request (11), routinely (3), and/or if specific criteria are met (6) e.g. prisoners identified as high risk. The average waiting time to get a test was 13 days, with the longest time being 30 days (in one prison) and the most frequent (7 to10 days). Pre- and post-test discussion was reported to be available in all prisons (11) which responded to the survey.

There is no policy on HIV, hepatitis B and hepatitis C testing in the prisons of Northern Ireland. The seroprevalence study[63] reported that only a small number of prisoners had been tested for HIV (14 per cent), either prior to incarceration or in prison. Even fewer had been tested for hepatitis B (10 per cent) and hepatitis C (7 per cent). A considerable percentage of prisoners who tested positive for hepatitis B and hepatitis C were unaware of their infection.

Counselling/discussion about tests

The MedFASH recommended standards for NHS HIV services stipulate that testing should be accompanied by pre- and post-test discussion appropriate to individual need. Such discussion can address some of the emotional impact of the test and diagnosis if the results are positive for HIV and also advise on protecting sexual partners and potential liability for transmitting the virus through sexual relations. Discussion is also important in cases where the result is negative in order to offer advice and support to reduce future risk.

The BHIVA guidelines state that 'there is no need for special counselling skills outside those which all clinicians (nurses and doctors) require for their daily practice'. This recent addition to the guidelines is meant to remove an unnecessarily onerous requirement around HIV-test discussion which could limit availability of the test. Certainly prison healthcare staff should all be competent to provide such discussion. There must, however, be an awareness of the particular challenges of a positive diagnosis in the prison setting, including issues of adherence to treatment and confidentiality.

More work should be done to identify issues which need to be covered in pre- and post-test discussion in the prison setting. One healthcare manager, for example, pointed out that the quality of pre-test discussion is crucial and there must be careful consideration of the amount and type of information provided.

[63] Supra, at 9.

The survey found that counselling/discussion was provided prior to the HIV test in 61 of the 63 prisons (97 per cent). In over 95 per cent of prisons, pre-test discussion was available on a routine basis. Slightly fewer – about 84 per cent – provided post-test discussion on a routine basis.

Although an overwhelming majority of prisons (more than 98 per cent) said that pre- and post-test counselling/discussion was available, anecdotal evidence suggests that this important step is sometimes disregarded. A prisoner who responded to the individual questionnaire said that he did not receive pre- or post-test counselling/discussion. His case was particularly worrying as he requested a test for HIV after being sexually abused in prison and his HIV status was positive.

Undiagnosed infection in prison

England and Wales

Further evidence that more needs to be done to test for HIV and other blood-borne viruses comes from statistics provided to the survey question on the numbers of prisoners currently being treated for HIV ('treatment' was not limited in definition to anti-retroviral therapy). When their responses are compared with the respective prison population figures, it becomes clear that healthcare centres are almost certainly unaware of substantial numbers of prisoners who have HIV.

The anonymous serosurvey from 1997 estimated that 0.3 per cent of the adult male and 1.2 per cent of the female prison population was HIV-positive.

Taking all 47 prisons for adult males, the aggregate reported population was 28,487; and the total number of prisoners being treated for HIV was 43. The 1997 anonymous serosurvey rate would predict that this population would include 85 prisoners who have HIV. Thus the rate of prisoners being treated for HIV in these prisons for adult males was half the rate suggested by the 1997 anonymous serosurvey. The rate used is based on a 1997 study, and could well therefore be a conservative estimate. The finding that half of prisoners who are HIV positive are going untreated in prison shows the huge challenge facing Prison Health.

Scotland and Northern Ireland

Asked for the number of HIV positive prisoners who were receiving treatment, ten Scottish prisons responded. The total number receiving treatment was fourteen; the highest number in a single establishment was six. Northern Ireland Prison Service reported no known HIV-positive prisoners.[64]

Comments on the quality of HIV prevention, testing, treatment and care

Prison healthcare managers were asked in the survey what more they would like to be doing when it came to prevention, testing and treatment of HIV, and what they considered the main barriers to working effectively in these areas.

In relation to prevention, there was a consistent demand for more (and up-to-date) education, information and staff training, a need we have already highlighted. The inability to provide condoms accessibly was identified by many as a barrier to effective prevention, as was the inability to access sterilising tablets or clean needles. These comments confirm the conclusions and recommendations of earlier sections of this briefing paper.

64 The rest of the survey specific to prisons with known HIV-positive prisoners was not completed.

We cite below some particular comments of interest relating to prevention taken from both prisons in England and Wales, and from prisons in Scotland:

What more would you like to do?

- "Condoms available without having to ask"
- "Community involvement in health promotion especially with minority ethnic groups"
- "Needle provision in custody and for those being released"
- "Make sterilising tablets available"
- "More education for staff and trainees/ and for inmates" [There were numerous comments to this effect, including requests for treatment updates]
- "GUM services to come into the prisons" [There were also calls for "regular clinics" or for "dedicated HIV clinics"].

What do you consider to be the key barriers?

- "Blinkered management (e.g. no needle exchange programmes, no condoms available)" [This represents the most frequent type of response]

When it came to discussion of HIV treatment and support for adherence, responses to the survey covered both actions taken to provide effective treatment and barriers which remain. Most of the prisons (39/63) reported that adherence to treatment was supported through such measures as:

- Drugs provided for 28 days
- Prisoners followed up by GUM clinic and visiting nurse specialist
- Careful monitoring of appointments
- Use of medical holds to avoid movements of prisoners to establishments where their treatment might not be sustainable
- Regular reviews, blood tests etc by a specialist nurse
- Regular discussions with in-house team and GUM/relevant staff also involved (e.g pharmacist, mental health team, substance misuse team, prison nurses).

In Scotland, healthcare managers cited steps to maintain adherence to the medical regime, including:

- Support and follow-up by BBV nurse
- One-to-one support
- Nutritional needs supported
- Nursing support and guidance
- Individualised care planning
- Regular specialist review.

But responses also highlighted difficulties around confidentiality [see below], patient mobility, and lack of both expertise and facilities. Comments included the following:

- "The conflict between the demands of custody, security and healthcare ["This included difficulties over confidentiality and the need for prison officer escorts]
- "High turnover of prisoners"/"Sentences too short to provide a quality service"
- "Too few patients with known HIV to maintain expertise"

- "Lack of staff"
- "Lack of multi-disciplinary team approach and a failure to include prisoner patients in establishing a protocol of care for HIV-positive prisoners"
- "Lack of research/evidence regarding the needs of prisoner patients and how to build new services"
- "Lack of healthcare facilities"

The issues of access to adequate treatment and confidentiality were highlighted by prisoners interviewed by a journalist working for *Positive Nation* magazine. For example, prison medical care was labelled a "paracetamol policy" (i.e. paracetamol tablets dispensed for any kind of health problem),

> "One of my pals, he was sick and didn't tell his family or any prison staff. … He went to hospital on Thursday and died on the Saturday. A screw came in first thing in the morning, singing, 'another one bites the dust.'"
>
> "I had to see the consultant handcuffed to a screw. … There's no confidentiality whatsoever. Anything you said would be all over the prison."
>
> "HIV and hep C are a bigger problem than you know. I know a lot of lads with hep and they don't take precautions as people might suspect them of having something. Prisons run on fear and people don't want to make their lives more difficult." [65]

Prisoners interviewed in focus groups and those who responded to the questionnaire also reported problems in healthcare, especially difficulties in accessing doctors and nurses, getting adequate medication or accessing treatment and the lack of healthcare staff knowledge about HIV. They also reported breaches of confidentiality with, for example, prison staff overheard talking about the health of a prisoner on the wing. A different view was put forward by some members of the focus groups. They saw that time in prison afforded them a good opportunity to access healthcare and to make use of the diagnostic options and treatments available.

Whilst there are examples of good practice and a clear desire amongst many healthcare managers to improve services, it is also clear that much more needs to be done to ensure adequate and equivalent standards of healthcare and treatment for prisoners living with HIV. Future work by NAT will examine in more detail how the challenges around treatment identified by respondents to the survey can best be addressed, as well as such questions as adherence to drug regimes and management of ARV (antiretroviral drugs) side-effects.

Discrimination, privacy and confidentiality

Issues of confidentiality have already been mentioned as a problem in the effective treatment of those living with HIV. Given the high levels of HIV-related stigma and discrimination which exist both in wider society and prisons, it is important that those receiving treatment for HIV have their confidentiality respected and their privacy protected. Moreover, a system in which confidentiality is compromised and people are as a result subject to prejudice, victimisation and abuse is not one which can encourage HIV testing.

England and Wales

The PRT/NAT survey asked healthcare managers about steps taken to ensure privacy and confidentiality. Only 46/63 responded. The low number of responses does not inspire confidence

[65] Positive Nation September 2005 Issue 115 p.21

that the needs of patients are being met. Of those who responded, 42/46 described some steps taken to ensure patient privacy.
The actions taken to protect privacy included:

- One-to-one administration of medication/ private consultations
- Access to medical records restricted to healthcare staff
- Documents being locked
- Separate and confidential filing system
- Prisoners escorted by healthcare officers not prison officers when possible
- Treatment supplied by outside GUM services.

When asked how they prevented and/or addressed discrimination on grounds of HIV, healthcare managers' responses included the following:

- "HIV discrimination was not an issue because they did not have any HIV-positive prisoners"
- "Disciplinary measures are in place if there is a problem"
- "Staff are informed to treat all patients using universal precautions"
- "Education for staff and prisoners is available if a prisoner discloses their HIV status"
- "Diversity training and education available to all staff on induction."

As is clear from the above quotations, some responses suggest an inadequate understanding of the pervasiveness, harm and challenges of HIV-related discrimination.

Evidence provided by prisoners and ex-prisoners shows that much remains to be done in some establishments. An HIV-positive woman prisoner reported experiencing discrimination from the prison officers, healthcare staff and fellow prisoners. She said that she was told she was not allowed in the kitchen because of her HIV status; a nurse also refused to take a sputum sample although in a sealed container. She also reported being verbally and physically abused and having seen other prisoners being abused by fellow prisoners and staff. In her words: "Until staff are educated properly, abuse will not stop."

Lack of knowledge about HIV and HIV-related discrimination amongst prisoners was also highlighted in the focus groups. Some prisoners confirmed that an HIV-positive prisoner would be physically and/or verbally abused, "pushed off the wing", or isolated if his/her status was known.

Scotland

Most prisons reported some provisions for ensuring privacy:

- Private consultations
- Prisoners' responsibility for their own medication
- In-house clinic nursing/medical staff.

SPS healthcare managers reported that discrimination was challenged, directly, on an individual basis; and by training and education to promote a positive working relationship between security staff, prisoner patients and healthcare staff.

Hepatitis

Prison Health has actively promoted a vaccination programme for hepatitis B. Over nine in ten (92 per cent) healthcare managers in the survey said that hepatitis B immunisation was made

available in the prison. Nine in ten prisons (57/63) said that they provided treatment for hepatitis.

Prison Health is continuing to expand its programme of vaccination for hepatitis B. Almost 15,000 prisoners received one or more doses of the vaccine in a programme targeted at local prisons, where prisoners are most likely to be received into the system from courts. Despite the fact that, in total, over 28,000 doses were administered in 2003, "the proportion of new receptions who are vaccinated remains low"[66].

Further research could be needed to establish the quality of the treatment provided for patients with hepatitis, and to examine the quality of the immunisation and prevention provisions.

All SPS prisons offer hepatitis B immunisation for new and current prisoners.
All prisoners known to have hepatitis C are also offered immunisation against hepatitis A.

Eight healthcare managers from Scotland said that treatment is available for hepatitis:
- Two said that treatment is provided via hospital;
- One said that HCV-positive prisoners are routinely vaccinated against hepatitis A and B if their sentence if their sentence is more than six months, or referred to a GP for follow-up if they are sentenced for less than six months;
- Another one said that the condition of a prisoner is assessed by a medical officer who then decides which treatment is appropriate. If necessary, the prisoner is referred to a specialist clinic outside the prison.

Northern Ireland Prison Service reported that effective treatment for hepatitis is available, but gave no further details.

There are particular challenges in treating those co-infected with HIV and hepatitis C. Again, better and up-to-date information is necessary within prisons to respond effectively.

Aftercare

Forty-eight healthcare managers responded when asked whether the prison made links with outside agencies as a means of following up treatment received in prison with aftercare; one in four managers did not respond and forty-three said that they established links with health agencies outside the prison. A small proportion of the remainder are prisons that rarely release prisoners directly into the community. Nonetheless, this finding suggests that prisons could still do more to develop working relationships with health agencies outside.

Specific steps taken to ensure continuity of care and treatment include:
- Visiting specialist who provides support upon release
- Prisoners interviewed before discharged and given letter to be passed on to their GP
- Telephone referral to make appointment for the next day following release
- Referral to local GU/HIV specialist within their area
- Nurse available for drafting a letter to be given to the prisoner's GP when they are released
- One-month medication provided.

To these should be added linking up those leaving prison with local voluntary sector agencies, in advance of release if possible.

[66](Prison Health Surveillance Unit, 2004)

All the prisons in Scotland which responded to the survey reported having links established with outside providers, mainly through:

- Liaison contacts with agencies by nurse lead/GP contact
- Prisoner patients' discharge monitored by specialist nurse
- Consultant and nursing referrals made to clients local IDU Department pre-discharge
- Link established with local NHS sexual health clinic prior to prisoner patient discharge
- Close contact by telephone and visits from nurse working at the hospital centre.

Responses to the PRT/NAT survey on healthcare policies

The seriousness, complexity and social context of HIV and hepatitis C suggest that each prison would benefit from a clear and comprehensive policy on both conditions. Such a prison policy should cover prevention, testing, treatment and care, as well as issues of confidentiality and stigma, and be communicated to both staff and prisoners.

The PRT/NAT survey found that many prisons in England and Wales still lack policies about HIV, hepatitis and sexual health.

- 23 (36 per cent of the survey sample) reported no HIV policy
- 38 (59 per cent) reported no sexual health policy
- 12 (19 per cent) had no hepatitis policy
- 3 of the 63 prisons did not respond to the question.

The special nature of the prison environment, increasing the risks of HIV transmission, has been well known for almost 20 years. In this light it does not seem possible that there could be a prison establishment in England and Wales that does not have a comprehensive HIV strategy, or that a structure to ensure that the strategy is continually updated might be lacking. Yet, as the survey revealed, over one third of prisons still have no HIV policy; over half still have no sexual health policy; and one in five have not developed a strategy for tackling hepatitis.

The survey explored the preferences of healthcare managers regarding different options for the development of new policies. When they were asked whether they would welcome a policy on: a) HIV only; b) HIV and sexual health; or c) HIV and hepatitis, the managers responded as follows:

- 41 (64 per cent) would welcome a policy for HIV and hepatitis
- 31 (48 per cent) would welcome a policy for HIV and sexual health
- 1 (2 per cent) said it would welcome a policy for HIV only.

(These add up to more than 100 per cent because some prison health care managers ticked more than one option.)

The monitoring of the implementation of policies is crucial. As pointed out by a healthcare manager, prisons can have a policy for dealing with a disease without having anything in writing; and prisons which actually have written policies may not implement them. Compliance must be with good practice not with good policy drafting.

9. Conclusion - rolling out good practice

The PRT/NAT survey of prisons, and the interviews and discussions with prisoners, as well as the available literature on the subject, all show clearly that UK prisons are not as yet responding effectively to HIV and hepatitis C. The current policy framework does not do enough to support prevention and harm minimisation, leaving prisoners vulnerable to infection. Furthermore, confidentiality is often compromised and quality of care erratic. Both prisoners themselves and wider society suffer as a result.

There are also particular challenges to developing good practice in UK prisons. One is the level of prison overcrowding. The number of prisoners in England and Wales has increased by more than 25,000 in the last 10 years, reaching 77,752 in November 2005,[67] with many establishments as a result seriously overcrowded[68]. At the end of May 2004, 17,000 prisoners were doubling up in cells designed for one.[69] Scottish prisons were also overcrowded[70]. High-risk behaviour, levels of prisoner-on-prisoner victimisation, and the impact of prison conditions on general prisoner health are all affected by such severe overcrowding. Another challenge to good practice is the frequent movement of prisoners between prisons, making continuity of care more difficult.

A briefing paper such as this inevitably emphasises matters of concern, and the still significant gap between healthcare for HIV and hepatitis C available elsewhere in society and that provided in prisons. But there were also examples of good practice cited in survey responses. It is clear that there are many staff in all parts of the Prison Service and the NHS committed to improving both the health of prisoners in general, and the response to HIV and hepatitis in particular. Survey responses highlighted a number of examples of effective education programmes (with updates), of liaison between prison health services and local GUM clinics, of involvement of the HIV voluntary sector, of harm minimisation such as hepatitis B immunisation, sharps bins on all wings, the running of 'harm minimisation groups' for prisoners by the substance misuse team.

The shift of responsibility for prison healthcare to PCTs is a great opportunity to establish equivalence of care for HIV and hepatitis C. Of course, healthcare remains outside PCT responsibility in private prisons. It will be important to avoid a two-tier system of prison healthcare, and to ensure that recommended practice is implemented consistently across the whole prison system for all places of detention.

As this briefing paper was being prepared, the government published its White Paper 'Commissioning a Patient-Led NHS', which requires Primary Care Trusts to end their provider role by the end of 2008, focussing instead on their commissioning function. Who those providers will be for prison healthcare remains to be seen. But the probable range of providers and their separation from commissioning bodies underlines the need for a single, comprehensive and agreed Framework to be in place for HIV and hepatitis C in prisons. This is the only way to ensure a high, consistent and equivalent standard of healthcare in our prisons for these two conditions.

[67] Prison population and accommodation briefing for 07th October 2005, HM Prison Service, Estate Planning and Management Group.
[68] On the impact of overcrowding in British prisons, see PRT, Prison Overcrowding: The Inside Story, by J. Levenson, London: Prison Reform Trust, 2002.
[69] House of Commons, Transcript of oral evidence to Home Affairs Select Committee, 25/05/2004.
[70] "Prison Service faces criticism", BBC News online, 25/06/04 (http://news.bbc.co.uk/1/hi/scotland/3837903.stm)

Recommendations

A body of clear recommendations stemming from research and practice has been developed over the past ten years. The recommendations which follow are not for the most part new but reinforce those made over the last few years by bodies such as the AIDS Advisory Committee (1995), the European Health in Prisons Project (2001), the All Party Parliamentary Group on AIDS (2001), the National AIDS and Prison Forum (2002). The survey results demonstrate plainly how urgent it is to improve the response to HIV and hepatitis in UK prisons. The way forward for policy on HIV and hepatitis in prisons has been clear for some time now. But the government has consistently failed to act on evidence and implement harm minimisation in prisons.

PRT and NAT recommend the following steps:

All prisoners should be provided with treatment, care and support services equivalent to those provided in the general community.

Prison healthcare services should develop mechanisms for gaining feedback from prisoners who are infected with HIV or hepatitis on the treatment they receive and the health-related problems they experience in prison.

All United Kingdom Prison Services should ensure regular anonymous serosurveys take place of HIV and hepatitis C infection, and of co-infection. The next serosurveys should take place within the next twelve months.

A best practice framework for prevention, treatment, care and support in relation to HIV and hepatitis C should be agreed across all United Kingdom Prison Services. Preparation of the framework should involve health services, clinicians and healthcare managers, the voluntary sector, prison governors and prisoners themselves.

Every prison establishment in the United Kingdom should have a prison policy on HIV and on hepatitis C which conforms with the proposed framework and which is effectively communicated to all staff and prisoners.

Recommendations on HIV and hepatitis C prevention

Harm minimisation:

The response in prisons to high risk behaviour should be based on the principle of harm minimisation: namely, that prisons and prison healthcare should work with prisoners to promote lower risk behaviour. In the prison setting, harm minimisation includes the provision of voluntary methadone maintenance programmes, disinfecting tablets, needle exchange programmes, and regular consultation with drug misusers about how best to meet their needs in prison.

Methadone maintenance therapy (MMT) should be extended so as to be available across all prison services in the UK to those who need and wish it.

Disinfecting tablets should be made available for cleaning needles (on the same basis of ease of access and confidentiality) with adequate information on how to use them. However, the

evidence clearly demonstrates that – strictly on health grounds – needle exchange would be more effective at preventing transmission of hepatitis C.

A needle exchange programme should be piloted in a group of identified prisons with the aim, if proven effective, of extending the programme to all prisons.

A safer tattooing programme should be piloted in a group of identified prisons with the aim, if proven effective, of extending the programme to all prisons.

Mandatory drug testing (MDT) should be vastly scaled down, eliminating random tests, which have not been effective at curbing opiate misuse. The funding currently devoted to MDT should be diverted to the provision of more effective drug awareness and drug treatment programmes.

Male and female condoms should be made available, free of charge, and easily accessible, in suitable locations, so that prisoners can obtain them confidentially without having to ask for them.

Dams and lubricants should be made available and free of charge to both men and women prisoners.

Arrangements (e.g. discrete and plentiful clinical waste/sanitary bins) should be made for condom disposal.

Education and health promotion:

Information and education on the risks of HIV and hepatitis, and basic facts about the two conditions and their treatment, should be provided for prisoners and staff, through an array of media and formats, and in a variety of settings, including direct contact with CARATs workers. It should include materials in different languages.

Information should be available as part of the induction process for all newly arrived prisoners on the testing and counselling available at the prison for HIV and hepatitis, and on the procedures for requesting a test.

Recommendations on testing for hepatitis and HIV

Prison healthcare should provide clear information as part of the induction process on the availability of HIV and hepatitis C tests. Healthcare staff should be trained to identify possible symptoms of HIV and hepatitis C, and possible risk behaviours, so as to offer the test appropriately and promptly to prisoners. Tests for HIV and hepatitis should be promptly and confidentially available to all prisoners on request.

Recommended standards on pre- and post-test discussion around HIV tests should be adhered to.

To encourage prisoners' co-operation, healthcare must be able to assure prisoners of confidentiality, a caring response (whatever the results), and protection against discrimination.

Recommendation on privacy, confidentiality and respect

Guidance on professional conduct in medicine should be provided to all uniformed staff so that they are aware of the rights of prisoners to confidentiality, privacy, and respect in health-related matters.

Recommendations on discrimination against prisoners with HIV or hepatitis C

All uniformed and healthcare staff should receive training on equality, addressing, in particular standards of care to reduce stigma and discrimination in relation to sexual orientation, race, and HIV/HCV status.

A mediation process to resolve discrimination complaints should be encouraged; and, if required, prison officers or healthcare staff should be instructed to attend further equality training.

The Home Office should commission research into the dynamics of prison sexual assault with the aim of identifying actions to reduce incidence of such assault.

Recommendation on responsibility for prison healthcare in Scotland

A review should be conducted about whether equivalence in prison healthcare in Scotland could better be achieved by a transfer of this responsibility for commissioning services from the Scottish Prison Service to the health service.

Appendix: survey instrument

Prison Healthcare Managers

Conducted December 2004

1. Average daily population

2. Policies

a. Does your establishment have an HIV policy?
If yes, please provide a copy.
Does your establishment have a sexual health policy? If yes, please provide a copy
Does your establishment have a blood-borne viruses policy? If yes, please provide a copy
Does your establishment use any plan/strategy (e.g. Local Health Delivery Plan) which mentions HIV? Please give reference and/or provide copy

b. NAT plans to develop a policy framework and best practice guidelines in relation to HIV in prisons. Which would be most useful to you (please tick one)
A policy/guidelines that focus specifically on HIV
A policy/guidelines that address HIV and sexual health
A policy/guidelines on HIV and blood-borne viruses

3. HIV Prevention

a. What steps are currently taken in your establishment to prevent the transmission of HIV?
Condoms available on application
Disinfecting tablets are available
Education covering risks of HIV infection
Please state the titles of educational materials provided to staff:
Please state the titles of educational materials provided to prisoners:

Please specify how and when prisoners/staff can access the materials:
Other materials provided on HIV. If yes, please specify
Maintenance prescribing available for opiate dependency
Detoxification programmes – If yes, please specify

b. What additional steps are taken in your establishment to prevent the transmission of Hepatitis B and C?
Hepatitis B immunisation programme in place
If yes, what protocol do you follow?

Education covering risks of Hepatitis B & C infection
Other materials provided on risks of Hepatitis B & C infection
Other prevention steps (please describe)

4. HIV testing

a. Is HIV testing available:
Routinely? (e.g. offered to all new prisoners)
On request?
Available only if specific criteria are met?
(please specify the criteria)

How long on average do prisoners wait for a test?
Is pre -test counselling provided?
If so, is it provided as a matter of course?
OR is it provided upon request?

Is post-test counselling provided?
If so, is it provided as a matter of course?
OR is it provided upon request

Who carries out testing ?
Prison health care staff
Local prison based GUM service
Other, please specify

b. Testing for other infections - What other tests are frequently offered?
Hep B
Hep C
Other STIs
Other (specify)

Please specify criteria for testing
- Routinely? (e.g. offered to all new prisoners)
- On request?
- Available only if specific criteria are met?

5. HIV treatment

a. What protocol do you follow for a prisoner who tests HIV-positive?
How many prisoners are currently receiving treatment? (Insert number)
What is the waiting period to receive treatment?
What steps are taken to ensure privacy for treatment?
What steps are taken to ensure compliance with treatment?
Please state how links are established with providers outside the prison to maintain treatment and support upon release.

b. Treatment for hepatitis B & C
What Protocol do you follow for someone who tests positive for Hepatitis B or C?

c. Post-exposure policy
Do you have a BBV post exposure management policy?
If yes, please specify

6. Additional Questions about how your establishment responds to HIV …

a. What are you most proud of in relation to addressing HIV in your prison?

b. What more would you like to be doing in relation to prevention, testing and treatment of HIV in your establishment?

c. What do you consider to be the key barriers to implementing effective prevention, testing and treatment for HIV in your establishment?

d. What training is given to staff in relation to working with prisoners who have HIV? Which staff receive training? How frequently is it provided?

e. Are you satisfied with the HIV educational materials available?
What types of materials do you think would be helpful …

please tick as many as you wish
updated leaflet
guide for prison staff
resource pack with fact files for prison staff
video for staff
video for inmates
posters for staff
posters for inmates
stickers for staff/inmates

f. What procedures are in place to prevent discrimination against prisoners who have HIV? How is any discrimination addressed when it occurs?

7. Additional questions about how your prison responds to other blood borne viruses

To what extent do you believe your healthcare centre is able to practice a harm minimisation approach in working with prisoners identified as high risk? Please explain.

What are you most proud of in relation to addressing other blood borne viruses in your prison?

Thank you for completing this survey.

HIV and hepatitis in UK prisons:

addressing prisoners' healthcare needs

Prisons are breeding grounds for blood-borne viruses because they hold, in overcrowded and adverse conditions, a population with previous experience of high-risk behaviour. This report, the first of its kind, draws on the findings of a survey of healthcare managers in prisons in England and Wales, Scotland and Northern Ireland.

It is being published at a time of a radical transformation in healthcare in prisons in England and Wales, as responsibility is being transferred from the Prison Service to Primary Care Trusts. This represents an unprecedented opportunity to move towards the principle of equivalence so long advocated by all with an interest in prison and public health.

The conclusions of the report are unequivocal: prisons' current policy and practice varies greatly between establishments. Overall they are failing to meet the needs of prisoners living with or at risk of HIV and other blood-borne viruses. Every prison should have a clear policy on HIV and hepatitis C. An agreed framework of best practice for prevention, treatment and care in relation to HIV and hepatitis C, based on the principles of harm minimisation, should be applied in all places of detention in the United Kingdom.

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