Tackling Blood Borne Viruses in Prison – A framework for best practice in the UK.

Contents

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1 Why tackle blood-borne viruses?

There has never been a more urgent need for prisons in the UK to tackle the spread of blood-borne viruses (BBVs). BBVs are viral infections passed between people through blood or other bodily fluids. BBVs can cause severe illness and death. Those of greatest concern in the prison context are HIV and hepatitis B (HBV) and C (HCV). You can find out more about BBVs in Appendix 2.

Key Fact:

63% of 2654 IDUs surveyed in England and Wales had been in a prison or a young offenders' establishment - 30% with a history of imprisonment had been in prison at least five times. 16% of those who had been in prison reported injecting whilst in prison.[5]

Prisoners are some of the most vulnerable people in the UK to BBV infection. Why?

- Because there is evidence of higher rates of BBVs amongst those received into the prison system.
- Because the sharing of injecting equipment for drug use poses a very high risk of BBV transmission – a high proportion of injecting drug users (IDUs) will be incarcerated at some point, often more than once.[1]
- Because there is some evidence that people who offend are at greater risk of BBV exposure due to heightened sexual risk taking.[2]
- Because prisons are an environment where risk practices (sharing injecting equipment, unprotected sex and tattooing) may continue to take place.[3,4]

Prisons are not isolated institutions and failing to respond effectively to BBVs puts everyone at risk; prisoners, staff, their families and the wider community. As well as harming individuals, BBV infection also uses up valuable prison healthcare resources. **Yet BBVs are preventable diseases**. As professionals responsible for healthcare of people in prison you owe it to prisoners and staff to accord the issue its proper priority and government policy makes it clear what is expected.[6,7,8]

Fortunately, there are prisons all over the country doing good work to get to grips with the problem. Simple measures can often make a big impact. In this guide, we aim to give accessible advice about what needs to be done and how services for people in prison around the country can move forward. We know that local circumstances can vary and that prison health services will be at different stages of development in their responses to BBVs. **The important point is to make progress towards best practice**. In this guide, we aim to assist you to think through where your establishment is now and where you would like to be. Whatever stage you are at, we intend that there will be useful guidance and tips for you and your establishment.

Who is this guide for?

This guide is intended as a practical resource for those who have responsibilities for the health and well being of prisoners and prison staff in the UK. In particular this is aimed at Prison Governors, Heads of Healthcare, Commissioners and other responsible staff in primary care trusts and health boards, and healthcare professionals who work with prisoners and prison staff. It will also be a valuable tool for those responsible for inspection, audit and performance management in prisons.

We are indebted to the Expert Working Group that informed the development of this guide. Members are listed in Appendix 1.

2 The four key aims

In order to strategically plan the response to tackling BBVs in your prison, it is necessary to be clear about what you are trying to achieve. There will be at least four key aims to strive for and to check progress against. These are:

☐ *Processes must be in place to prevent the onward transmission of BBVs.*

This requires:

- prisoners and staff must understand what BBVs are, how they are transmitted and how this can be prevented,
- prisoners and staff also having the **means** to prevent the transmission of BBVs. For example, it is less than helpful to instruct prisoners and staff on the value of HBV vaccination without making it available.

☐ *Processes must be in place to enable the early diagnosis of BBVs.*

This requires:

- the availability of free, voluntary and confidential testing services, with pre and post test discussion provided in accordance with good practice guidelines, [See UK National Guidelines on HIV testing 2006, and Hepatitis C: essential information for professionals and guidance on testing 2004.[9, 10]
- the availability of information for prisoners and staff about what BBV tests are currently available and what the results mean.

☐ *High quality treatment and care for those infected with BBVs must be available.*

This requires:

- access to high quality, confidential, clinical primary care services, with expertise in BBVs,
- access to high quality, confidential secondary care, which should include, hepatology services, genitourinary medicine (GUM), substance misuse treatment, mental health services and advice and social support.
- dedicated outreach into prisons of relevant health services to minimise the need for movement of prisoners between different settings.

☐ *The prison environment must be one where prisoners and staff are treated with respect and robust action is taken to prevent and respond to stigmatising or discriminatory treatment of anyone because they have (or are suspected of having) a BBV infection.*

This requires:

- educational interventions for prisoners and staff that challenge myths and inaccuracies about BBVs, raise awareness about the harm that discriminatory practice can cause (e.g. poor prison relations, reluctance to test) and allow people to clarify understandings and unwarranted fears,
- robust policies that clearly state that discrimination related to BBV infection will not be tolerated, and the measures that will be enacted to prevent and respond to it.

In the following sections, we will be looking in more detail about how these aims can be met in practice but here it is important to say that these four elements are the essential features that every establishment should be working towards in its response to BBVs in prison.

Practice Idea:

Don't 're-invent the wheel'. Use professional networks to identify prisons with established BBV policies – these can easily be adapted to your establishment's needs.

"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. Male Prisoner[11]"

3 Strategic policy and leadership

Leadership and policy development are important to 'prepare the ground' for any changes that an effective strategic response to BBVs may entail. This should include five key elements:

Demonstrating leadership – Professionals providing services for prisoners must strongly communicate that BBV work is a priority. How can this be done?

- by taking personal responsibility for setting in motion the necessary strategic development processes
- by assembling the right team to take work forward
- by ensuring the team has sufficient seniority to take decisions and implement them.
- by giving them the resources and authority to do what is necessary
- by taking a personal interest in monitoring results.

Allocating responsibility – Responsibility for tackling BBVs in prison is shared between the prison service, the local NHS, local community organisations and prisoners themselves. The following therefore need to be included in determining the response for your prison:

- custodial staff
- healthcare managers
- NHS commissioners
- primary and secondary healthcare staff
- substance misuse workers
- external professionals providing health and social care services.

It would be good practice to involve prisoners (or their advocates) as appropriate. It is vital to be explicit about accountabilities; no-one should be in any doubt about what they are expected to contribute to the prison's efforts to tackle BBVs.

Developing a policy – A written prison policy is necessary to clearly communicate a service's intended aims and actions to tackle BBVs. Some ideas for what this might include are detailed in our checklist overleaf. This need not be a lengthy or complex document. Existing policies can be updated or elements of other policies incorporated (e.g. health and safety, drugs, equality or confidentiality policies etc.). National guidance is available and your policy should take account of this.[12,13]

Involving staff – It is important to bring all relevant staff groups on board early and proper consultation is essential. This should include:

- information on the urgency of addressing BBVs in prison and the benefit to staff, prisoners and the community alike,
- clarity on the policy and resulting actions to be taken,
- education and advice that gives factual information as well as enabling staff to clarify uncertainties and safely discuss anxieties,
- building competencies by providing practice-based instruction on what staff need to do to prevent the spread of BBVs and how to relate in a professional and non-discriminatory way to those who are infected or at risk.

Practice Idea:

Don't assume that allocating responsibility means yet another working group - existing prison working groups on drugs, healthcare services or other aspects of prison management can take on the role, with newly co-opted members if necessary.

3 Strategic policy and leadership

Leadership is especially important here; staff should understand that the agenda on tackling BBVs must move forward and that a well-planned strategic response is the best way to protect the interests of all who live and work in prisons.

Working in partnership – Prisons working alone cannot effectively tackle BBVs and neither should they be expected to. Commissioning of prison health services is now the responsibility of the NHS and Commissioners must be assertively encouraged and enabled to play their part. Many non-statutory organisations have a history of effective work with prisons but many more could make a real contribution to prison BBV work if they were supported and encouraged to take the first step. It is important to work together to identify the mutual benefits of greater involvement of community services and voluntary organisations, and overcome any barriers that currently hinder this.

Your BBV Policy – A Checklist

- Basic facts: how BBVs are spread, prevented and treated. Why prisons and PCTs must respond effectively. ☑
- The aims and objectives of the policy. How it will be monitored and updated. Who is responsible for it. ☑
- Measures to be taken to educate and inform prisoners and staff about BBVs. ☑
- Guidance on minimising the risk of BBV exposure for staff and prisoners and responding to exposure incidents. ☑
- Services to enable prisoners to be confidentially vaccinated and/or tested, and have access to treatment for BBVs. ☑
- Relevant occupational health arrangements for staff.[14] ☑
- Measures to support and advise infected prisoners and staff. ☑
- Measures to support continuity of care into the community. ☑
- Policy statements on confidentiality, non-discrimination and respectful treatment. ☑
- Sources of further information and advice. ☑

4 Introducing the prisoner pathway

A potentially helpful model for strategically planning your response is to map out the prisoner's experience as a pathway through incarceration. Our model (see Appendix 3) maps this out in four key stages; yours might include more detail relating to the unique features of your prison. **The objective is to identify specific points in the pathway where there are opportunities to take action.**

Reception (custody period = 24hrs to 1 week) – This can be a difficult and stressful time, especially for new prisoners but there is potential to identify prisoners at risk so that follow-up testing, treatment and support can be provided and to get immediate treatment to those who need it. Super-accelerated HBV vaccination can commence (see phase 1 for details).

Phase 1 (custody period = 1 month or less) – During this period, basic awareness-raising should take place and BBV testing should be offered, with signposting to appropriate services in the community for those released. While many prisoners will be detained for only a short time, HBV vaccination for those over 18 can be completed in 21 days using a super-accelerated schedule (0, 7, 21 days). For young offenders aged up to 18, the attending physician can prescribe the super-accelerated schedule on an individual basis. Where this is not possible, the accelerated schedule should be used (0, 1, 2 months).

Phase 2 (custody period = 2–5 months) – For those detained for several months, there are opportunities to carry out more involved interventions. By this time, all consenting prisoners should have been fully vaccinated (three doses) against HBV. Health education should be provided that enables prisoners to assess personal risk and complete voluntary BBV testing. Secondary care treatment (e.g. GUM, hepatology) should be accessed where necessary and social and psychological support should be offered for prisoners who need help in coming to terms with a positive diagnosis. Risk reduction and harm minimisation education is vital for all those diagnosed or at risk.

Phase 3 (custody period = 6 months or more) – At this stage, treatment relationships with external secondary care providers (hepatology, GUM) should be well established for those diagnosed positive, where appropriate. The emphasis should also be on social and psychological support for living with a long-term condition (particularly for those with HCV and HIV).

Transfer – For transferred prisoners, continuity of care is vital to enable HBV vaccination to be completed and outstanding BBV test results to be appropriately communicated. The principle of continuity of care applies to any BBV treatment commenced to minimise the disruption caused. This is particularly important in the case of anti-retroviral therapy for those living with HIV where even missing a single dose can have serious health implications.

Resettlement – Specific BBV related needs must be integrated into release planning. The aim should be to ensure that prisoners are linked into local primary care and community services and that there is minimal disruption to ongoing clinical treatment. Access to ongoing drug treatment and mental health support will be vital for many. Access to benefits, employment/training, suitable accommodation and family/social support are also vital in providing a stable environment that can help prisoners to reduce their risk-taking and better cope with any positive diagnosis received.

A flexible and sustainable approach based on steady progress offers the best method for equipping staff and prisoners with the knowledge, competencies and means to prevent BBV transmission and respond to the needs of those infected. In the following sections we look at these aspects in more detail.

HMP Buckley Hall – HCV Clinic

HMP Buckley Hall won a Butler Trust award in 2000 for its exceptional work in addressing HCV infection among prisoners. A (PCT funded) HCV clinic is provided twice weekly and staffed by two specially trained nurses.

Anonymous and confidential HCV testing is offered as part of the initial reception health screen. An HCV clinic referral will be made if requested and following reported risk behaviour. Patients are usually seen within 1-2 weeks. Nurses assess the need for testing and provide pre and post test information and advice. Where indicated and requested by the patient, blood testing is carried out. Results are usually obtained within six weeks.

If negative, individualised harm minimisation education is provided. A positive result leads to additional counselling to enable the patient to understand the result and come to terms with the diagnosis.

Experience indicates that clinic access in the days following a positive diagnosis is especially important. As well as written information, individual contact has proved important in responding to prisoner needs.

Referrals are made to NHS hepatology services where there are three or more months to serve. If serving a shorter sentence, the prisoner will be signposted to a GP in his area of residence. HIV testing is also offered and HIV positive patients are referred to in-reach GUM services. The clinic is now seeking to establish an HCV support group for prisoners.

For further information:
Sarah Gordon, HMP Buckley Hall, 01706 514300

5 Reception and induction

Experienced prison staff know that reception is a time of particularly heightened vulnerability for many prisoners, especially those imprisoned for the first time. Clearly, reception is not the right time to begin complex BBV related work when there may well be other seemingly more pressing needs. However, there are a significant number of key actions that can be taken to prepare the ground for more involved activities at a later stage. HBV vaccination for those over 18 can be completed in 21 days using a super-accelerated schedule (0, 7, 21 days). For young offenders aged up to 18, the attending physician can prescribe the super-accelerated schedule on an individual basis. Where this is not possible, the accelerated schedule should be used (0, 1, 2 months).

Reception – Every prisoner must undergo health reception screening. This presents an important opportunity to:

- identify those already being treated for BBVs – this is very important in the case of prisoners taking HIV anti-retroviral therapy (see below),
- identify those at significant risk due to injecting drug misuse or other risk for follow-up within one month.

Induction – Arrangements to induct prisoners into the establishment will vary but it is customary to include information about healthcare services. This can be used as an opportunity to inform prisoners, without unnecessarily alarming them, about the risks of BBV transmission, the steps the prison is taking to control the risk and how prisoners can access HBV vaccination and BBV testing, treatment and support. This is an opportunity to provide basic facts, which can be followed up with more in-depth education and individualised support as necessary. As well as factual information, induction is an opportunity to assert the prison's ethos and values that discriminatory behaviour related to BBV status is unacceptable. The goal is to create a climate where those at risk feel able to access healthcare services and support. Done well, it also imparts the message that the establishment takes prisoner welfare seriously.

Prisoners and HIV Anti-retroviral Treatment

Reception health screening must urgently prioritise continuity of HIV Anti-Retroviral Treatment (ART) for prisoners who are taking it. Here, nothing less than excellence in practice will do. ART is a drug combination taken to control the replication of HIV in the body and to protect the immune system. It is literally life-saving medication. Getting the drug combination right can be complex and ART can be a demanding treatment regime to follow: drugs have to be taken in the correct sequence, at the right time according to specific instructions - some must be taken with food, some must be refrigerated. **At least 95% adherence to treatment is required -` even one or two missed doses can be seriously problematic.**[15]

Practice Idea:

NAM produces a poster that depicts the major ART drugs. This can be used to help a confused or uncertain prisoner to identify their current treatment combination.
Contact NAM for details, 020 7840 0050

As well as the health implications, treatment disruption is likely to cause very significant anxiety to any prisoner receiving ART. Every prison must therefore have the following in place:

- a clinical protocol for the management of newly received prisoners taking ART followed by referral to an HIV specialist as soon as is practicable but no later than two months of reception,
- immediate access to supplies of drugs making up common ART combinations,
- referral to an HIV specialist within one month if there is any change or interruption in treatment. Local HIV specialists should be consulted for advice.

Induction & Reception – A Checklist

- Use the full reception healthcare screening process to identify BBV related risk and offer HBV vaccination – put mechanisms in place for trained staff to confidentially follow this up. ✓

- Ensure that the induction process includes brief information about what BBVs are and how they are prevented and treated. Stress prison-related risks: sharing injecting equipment, tattooing and unprotected sex. ✓

- Inform prisoners about how they can access items to help them to avoid risk while in prison: e.g. condoms, disinfectant tablets. ✓

- Inform prisoners about the BBV related services available: HBV vaccination, BBV testing and treatment, and how they can access them. Stress that services are voluntary and confidential. ✓

- Give accessible, written information that reinforces verbal information. ✓

- Identify a named individual that prisoners can access in confidence for information or advice about the services offered. ✓

- Ensure that BBVs are included in instruction about equality and anti-bullying. Prisoners and staff need to understand that bullying, harassment, speculation or gossip related to another's BBV status is unacceptable and could be considered a breach of discipline. ✓

6 Custody and transfers

The length of a prisoner's sentence will determine how much work can be done regarding BBVs. Naturally, the aim is to do as much as possible to meet prisoner needs in whatever time is available and to assure continuity when the prisoner is released or transferred. Appendix 3 presents a timeline for the completion of key tasks. However, your own map of the prisoner pathway should identify what is feasible for your establishment (but note – every single dose of HBV vaccination is important). **Remember, the aim is progress – your own map and strategy should be realistic but challenging.** The following sections outline the custody phases in more detail.

Custody phase 1 (1 month or less) – a significant number of prisoners will spend a month or less in prison. Therefore, the aim here is to build upon reception and induction activities (see section 5) or to prepare the prisoner for transfer or release. During this phase, in addition to reception/induction activities, the following should be completed:

- Every prisoner already receiving anti-retroviral or HCV treatment should have their treatment immediately maintained and be under the care of a specialist consultant.
- Every prisoner requiring it should be under the care of clinical staff and CARATs regarding substance misuse needs. This should include maintenance therapy where clinically indicated and harm minimisation advice that includes information on BBVs.[16]
- HBV vaccinations should be completed (on a super-accelerated schedule). This should include information on how prisoners can complete vaccination and receive a booster in the community if released before completion.
- All prisoners requiring them should have begun to obtain condoms, dental dams and disinfectant tablets where available (see *Condoms and Syringes - Current Policy*).

Phase 2 (2–5 months) – Building on phase 1, the emphasis here should be on enabling prisoners to gain more detailed information, to assess their own risk behaviour and to consider the benefit of BBV testing via personalised information and advice. This can be done by prison healthcare staff or visiting professionals. Access to secondary care services for those who need them following testing should be initiated. During this phase:

- Prisoners involved in injecting drug use should be offered an appointment with a nurse or other advisor that includes an assessment of personal risk of BBV infection and information about currently available tests and treatments. For those undergoing BBV testing, pre and post-test discussion is essential.
- Results for HIV tests should be returned within one week. For an HCV test, enough blood should be taken so that if the initial anti-HCV test is positive, it can be followed immediately by an HCV RNA test and the results given at the same time. Results should be returned within two weeks. Risk reduction advice for all, with psychological support for those testing positive will be important to accompany this testing process.

- Referral to NHS hepatology or HIV specialists where appropriate, according to locally developed management protocols, must be arranged without delay when a positive diagnosis is received.
- Every prisoner who requires ongoing access to condoms or (where available) disinfectant tablets must be in receipt of them.

Phase 3 (6 months or more) – During this phase there are two key priorities – ensuring that uninfected prisoners remain so during imprisonment and providing coordinated, ongoing medical treatment and support to infected prisoners who need it. During this phase:

- There must be continuing access to condoms.
- Disinfectant tablets should be made available to clean drugs paraphanalia for those who continue to use in prison.
- Treatment relationships with HIV and/or hepatology specialists should be well underway, as should tailored substance misuse interventions.
- Those following medication regimes must be enabled and supported to follow them. Prison pharmacists can assist by developing appropriate drug administration protocols and advising prisoners on adherence. Care must be taken to ensure that medication administration does not inadvertently lead to disclosure of a prisoner's BBV status. Wherever possible, in-possession medication should be encouraged.
- Psychological and social support should be offered to enable infected prisoners to come to terms with living with a long-term condition and, within the limits of prison life, to make the lifestyle changes necessary to preserve and improve their health. A range of staff can assist, including GUM advisors, nutritionists, substance misuse workers, physical education staff, counsellors and mental health professionals as well as primary and secondary care staff and custody officers.

Transfer – Because the prison population is a highly mobile one, as far as possible, BBV-related needs must be integrated into planning for transfer. Key factors to consider in relation to transfer issues are outlined in our queries checklist overleaf. Local arrangements in your prison will inform how these issues are addressed but it will be important to reassure prisoners that as far as possible, steps have been taken to minimise disruption. **Remember, what may be routine administrative issues for the establishment can be regarded by prisoners as very serious medical concerns (e.g. ensuring the continuity of ART treatment).**

HMP Wandsworth – THT In-reach

Since 2005, a partnership between HMP Wandsworth and the Terrence Higgins Trust (THT) has led to the provision of one-to-one support and information sessions for prisoners. An innovative aspect of the project is that appointments can be arranged via other prisoners providing peer support. For some prisoners, this enables greater accessibility as they do not have to make their request via an officer or member of healthcare staff.

Workers from the Outreach team at THT visit the prison on a monthly basis giving confidential information and support. This may address issues such as sexual health, sexuality, discrimination, relationships or HIV, as well as broader aspects of prison life. The team cannot issue condoms but can signpost on how these can be obtained within the prison. The team see around 6-8 men per visit. The in-reach activity is funded by THT.

For further information: Keith Burgess, Head of Onslow Centre, HMP Wandsworth, 020 8588 4000, or Stephen Connolly, LADS Team, Terrence Higgins Trust, 020 7812 1600

Condoms and Syringes – Current Policy

Ultimately, much BBV related work in prisons aims to educate prisoners to adopt less risky behaviours. This requires giving them the means to do so. It is important to have an accurate understanding of what the national policy position is on providing access to condoms and clean syringes.

Condom distribution –
England and Wales – prisons can make condoms, dental dams and water based lubricants available to prisoners via the 'Dear Dr. letter' policy where there is a sexual risk of HIV transmission.[17] A Patient Group Directive (PGD) can be helpful in enabling nursing staff to 'prescribe' condoms. Best practice is to distribute condoms through prison nurses under a PGD directive with no questions asked.

Scotland – Condom and dental dam provision was successfully piloted in HMP Greenock in 2005. The provision of condoms and dental dams have been adopted as policy and this is now in the stage of implementation across the Scottish Prison estate.

Northern Ireland – At the time of publication condoms are not available for prisoners.

Clean injecting equipment –
Currently, no UK prison offers needle exchange (NEX). However, the Scottish Prison Service hopes to pilot NEX starting in late 2007. HMP Aberdeen has been providing injecting paraphernalia such as citric, water, swabs, spoons and information on safer injecting since late 2005. The Scottish Prison Service also stores needle exchange packs for prisoners on reception into prison and returns them on release, if they are still required.

In the absence of NEX, disinfectant tablets are available to prisoners in Scotland and, following a pilot in four prisons in late 2006, will be rolled out nationally in England and Wales in early 2007.
In Northern Ireland, there is no provision of disinfectant tablets.

The position is clear **– in England, Wales and Scotland there is no bar on the provision of condoms to prisoners and indeed prisons are expected to make them available where there is a risk of HIV transmission. Disinfectant tablets should also be made available.**

Practice Idea:

As well as updated Inmate Medical Records, record HBV vaccinations on a small card, to be retained by prisoners. Prisoners could give this to staff following transfer allowing nurses to easily identify those with injections outstanding.

Transfer Questions and Concerns:

- Is it in the prisoner's interests to suggest a 'medical hold' to preserve continuity of external specialist hepatology/HIV treatment? Ask the prisoner's HIV/hepatitis clinician for their view on the medical advisability/timing of transfer, giving them at least 24 hours notice.

- Is the Inmate Medical Record (IMR) comprehensive and up-to-date regarding BBV-related needs/treatment?

- How will any outstanding BBV test results be communicated following the move?

- If the prisoner is taking complex medication (e.g. ART or Interferon), have prior arrangements been made with the new prison to continue this without disruption?

- If the prisoner is accessing condoms or disinfectant tablets to reduce risk, will they be able to obtain them in the new prison?

HMP Maghaberry, Northern Ireland – Drugs & BBV Risk

Funded by HMP Maghaberry, Northlands drugs workers and trained custodial staff deliver a 10-week group-based educational and support intervention for prisoners.

Using a harm-minimisation approach, the programme examines the broader aspects of drug-related risk (physical, social, emotional and legal). One of the sessions is entirely devoted to BBVs. A Home Office educational video is used to introduce the subject, which was produced for a prison audience. Participants are given factual information, often by a member of the medical services team. This is followed by a group discussion where participants can clarify information and discuss issues from their own perspective.

Although written materials are available, facilitators have found that prisoners appreciate the opportunity for discussion and this is especially important for prisoners with low basic skills levels.

For further information: Christine McClements, Northlands, 028 777 204 86

HMP Littlehey – Real Voices

HMP Littlehey's award-winning Real Voices project was set up in 2002 in collaboration with local NHS services. The aims of the project are to reduce isolation by giving prisoners a forum to discuss issues of sexuality in a secure, safe, and non-judgemental environment; to promote safer sexual practices through health education; and to promote HBV vaccination/testing and testing for HIV. The project also 'prescribes' condoms in accordance with a locally devised protocol.

The project advertises within the prison and is usually oversubscribed, attracting 25 – 30 men to each monthly session. Prisoners help to set the agenda and can raise problems and issues related to sex and sexuality; obtaining information and advice where needed. Outside speakers, videos and group work helps to stimulate discussion. This might focus on issues of identity, relationships, sexual health, discrimination etc.

Some participants are living with HIV and the group benefits from visits by the local HIV Nurse Specialist, HIV counsellor and HIV social worker. Referrals can be made within the prison to the GUM clinic session for confidential HIV and Hepatitis testing. Referrals can also be made to secondary care services in the community where necessary. The Clinical Nurse Manager, who leads this groundbreaking project, has found that it has helped to foster greater awareness among staff and prisoners alike regarding sexual diversity and given prisoners a valued space to enhance their sexual health in a broader sense. The project is supported by Huntingdonshire PCT.

For further information: Helen Burr, Clinical Nurse Manager, HMP Littlehey, 01480 333 000

7 Release and Resettlement

The resettlement of prisoners is a specialist and complex area of offender management requiring skilled multi-agency intervention. While every prisoner is unique, the general resettlement needs of prisoners are well known. These generally include:

- Secure and appropriate accommodation
- Education and training
- Employment (people living with HIV may face particular barriers in finding employment)
- Fast and efficient access to welfare benefits
- Ongoing substance misuse treatment
- Ongoing mental health services and continuity of healthcare
- Support in re-establishing and rebuilding relationships with families[18]

Effective resettlement benefits prisoners in numerous ways. Done well, it can also address BBV-related needs. For example, it is obvious that secure accommodation, employment and substance misuse treatment are critical in enabling prisoners to move away from chaotic lifestyles where BBV risk behaviour is more likely. However, in addition to meeting general resettlement needs, some prisoners will have specific BBV related needs; either because they are living with a BBV or remain at considerable risk. Therefore, vulnerable prisoners should be:

- Supported and enabled to identify a GP in their intended area of residence via prison resettlement services (see practice idea).
- Provided with appropriate appointments with GUM or other clinics arranged before discharge.
- Offered HBV vaccination for sexual partners of prisoners via their GP, this can be offered through an anonymous scheme whereby the partner's details are given to the local Consultant in Communicable Disease Control (CCDC) for contact tracing and action.
- Assured of continuity of any BBV-related clinical care initiated in prison via effective liaison between prison and community healthcare services. Ideally, secondary care providers in the community should be notified of planned release in advance wherever possible. Protocols must be developed to facilitate appropriate sharing of prisoners' personal healthcare information in accordance with data protection requirements.
- Given adequate supplies of medication to cover the transitional period. While this will be informed by clinical judgement, the amount given should be sufficient to cover circumstances where prisoners experience extended delays in accessing healthcare services in the community.
- Effectively referred via CARATS to community drug treatment teams that can offer harm minimisation approaches in the community, including Needle Exchange (NEX). Those previously involved in chaotic forms of sex work should also be advised of any local support projects.

Practice Idea:

Organise supervised sessions where prisoners due for release can make free calls to NHS Direct. NHS Direct provides information on accessing local NHS services including GPs. The telephone could be system 'locked' to dial only NHS Direct numbers. A risk-assessed prisoner could be trained to assist with the administration of the sessions under the supervision of resettlement officers,
NHS Direct - England, Wales & Northern Ireland: 0845 46 47
NHS Direct - Scotland: 08454 24 24 24

Ensuring Positive Futures

"EPF is an innovative employability programme for people living with HIV in the UK. Careers advice, training and welfare support are just some of the ways that the programme works with HIV positive people to help them train, find employment and retain jobs. The programme is open to all HIV positive people including ex-offenders. The programme also works with employers and trade unions to create a fair working environment for HIV positive people. See www.e-pf.org.uk for more details."

Practice Idea:

The Telephone Helpline Association publishes a directory of over 1000 UK-based helplines responding to issues such as: health, disability, mental health, children and young people, rape and sexual abuse, drugs and alcohol, HIV and AIDS, hepatitis C, family and parenting and legal and civil rights. Prison education services could work with prisoners to identify and develop a list of local helplines for your area. An attractively designed and appropriately presented list could then be given to prisoners prior to release.

The directory costs £20 and can be ordered on Tel: 020 7939 0641

For more information see: www.helplines.org.uk

- Signposted, via resettlement services, to local and national telephone helplines and crisis services that can assist. This should include those specifically offering support to those living with BBVs. A simple information resource, designed with prisoners in mind, should be made available to all released prisoners (see practice idea).

Presented below are the goals of resettlement as defined by HMPS for England and Wales. It is important to remember that involving prisoners as much as possible in arranging their own healthcare prior to release is a highly desirable resettlement activity in its own right, which can contribute to broader resettlement aims.

The Goals of Resettlement

"In general terms, a resettlement regime: concentrates on preparation for release and resettlement; reduces institutionalisation; requires prisoners to exercise considerable and increasing levels of personal responsibility; accords prisoners considerable and increasing levels of trust; progressively tests the ability of prisoners to function independently and in the community; and enables prisoners to return to the community with a reduced risk of re-offending and risk of harm to the public.[19]"

"Voluntary and community organisations are an established part of the services and support in many establishments...The relationship between the Prison Service and voluntary and community groups is likely to grow rather than diminish as the Prison Service begins to focus more on resettlement and reduction in the rates of re-offending. It is therefore vital that this relationship should be made to work as effectively as possible." Rt. Hon Paul Boateng MP, then Minister for Prisons and Probation, 2001[23]"

Practice Idea:

Avoid the trap of allowing partnerships with external agencies to become 'stale' and continue out of habit. New organisations are regularly formed that may better meet your strategic aims. The strategy development group should be tasked with devising mechanisms for keeping this under review.

8 Involving community partners

It is well established that external agencies have a vital role to play in many facets of prison work. CLINKS (the national organisation supporting voluntary work with offenders) claims that over 900 voluntary organisations provide over 2000 services to offenders, with more than 7000 volunteers contributing to offender rehabilitation.[20] However, some organisations can still experience a 'glass wall', which makes it more difficult for them to gain access to prisons. This is especially the case for organisations working with prisoners from minority ethnic backgrounds, lesbian and gay prisoners and those focussing on HIV and AIDS.[21] Yet these are often the very organisations with the greatest expertise in BBV-related work. It is therefore important to:

- Review the profile of voluntary and community organisations working in your prison and ensure that organisations with specific BBV expertise are included.
- If not, identify the barriers to their involvement and use your strategic plan to devise actions to attract and integrate them.
- Where there are already such organisations in place, keep relationships under regular review (see practice idea).

CLINKS offers general good practice guidance on partnerships with voluntary and community organisations as well as an online directory of organisations already working in prisons.[22] Reproduced overleaf is their list of key questions to consider in initiating new relationships with external voluntary and community organisations. In addition to general principles, the following issues may require consideration when initiating new partnerships with organisations specialising in BBV-related work:

- Many such agencies utilise harm minimisation approaches in relation to drug misuse and sexual risk. Misunderstanding and differences in organisational culture can lead to tensions if not addressed. This needs to be discussed and resolved before work commences.
- Given the stigma and discrimination attached to BBVs, especially HIV, organisations working in this field are often highly conscious of issues of disclosure and confidentiality and will expect to work to a high standard in this regard. Explicit negotiation will need to take place to maintain a balance between observing strict confidentiality and the expectations of prisons regarding disclosure of information. Discussions should also consider mutually acceptable operational arrangements for ensuring that prisoners can access in-reach services confidentially.
- Due to their historical origins, many such organisations have a 'user-led' ethos and include staff and volunteers with direct experience of the issues they address (e.g. former drug users, HIV positive people, gay men etc.). Steps must be taken to ensure that anti-discriminatory policy, practice and procedure offers equal protection from discrimination for external workers in the prison.

HMP Holloway – Positively Women

Positively Women (a national women's HIV charity) and the Women's Health Clinic at HMP Holloway (provided by the Royal Free Hospital NHS Trust) work collaboratively to provide a highly responsive advice and support service for women prisoners living with HIV. The collaboration builds on the long-term relationship that Positively Women has with HMP Holloway.

Working in partnership with the clinic Health Advisors, Positively Women's Drugs and Prison Worker offers person-centred support to clients in living well with HIV and addressing the multifaceted problems that HIV positive women in prison face. Clients are referred via the clinic and can obtain advice and support on a range of issues affecting them.

A significant number of clients are injecting drug users and/or sex workers and experience has shown that for many, issues of HIV run alongside concerns about substance misuse, immigration, childcare and mental health. Responding to their needs as women living with HIV generally requires a holistic and multi-agency response, which the Drugs and Prison Worker seeks to coordinate.

For further information:
Maria Hortelao, Positively Women, 020 7713 0444

Key Questions for Initiating New Working Partnerships

- Who are you going to invite?
- What role do you see them playing?
- Why do you want to involve external organisations in your work?
- Where are they going to work and who is going to support them?
- When do you want them to start and how often will you want them to come into your establishment: daily, weekly monthly etc.?
- How will their involvement be organised?[22]

9 Meeting the needs of staff

This section should be read in conjunction with the appropriate Health and Safety and Occupational Health guidance for the prison service as a whole and your establishment. There is a legal obligation to look after the health and safety of all prison staff and this includes reducing the risk from BBVs as far as is reasonably practicable. See the 'Key Resources' box overleaf for BBV-related guidance.

Training - All staff should receive ongoing BBV training to enable them to identify the risks of transmission and how to prevent them. Advanced training can include more about living with BBVs, from treatment to the stigma and discrimination faced by people living with BBVs, and particularly HIV. You may want to consider bringing in people from voluntary or community organisations as part of the training. It will be important to make clear the need to treat prisoners living with BBVs without stigma or discrimination. Training can enable staff to protect themselves and reduce discrimination. As a more realistic understanding of transmission risks develop, the risk of discriminatory treatment of prisoners with BBVs can be reduced.

Prevention - The risk of transmission of BBVs from prisoners to prison staff is very small providing proper risk-reduction steps are taken. All staff should be made aware of established health and safety procedures and how to follow them.

A vaccine exists for HBV and an immunisation programme should be set up to minimise the likelihood of HBV transmission to those staff at risk as required in England and Wales by PSO 8900 and recommended by the Scottish Executive. This programme needs to have an identified administrator who can liaise with either in-house or external occupational health. All staff at risk of exposure should be offered immunisation and must attend an initial appointment. The programme should be monitored, audited and reviewed - careful record-keeping is also essential. Annexe 9 to Guidance Note 02/2005, 'Setting up an Immunisation Programme for HMP staff', provides very useful and important detailed information.[24]

Dealing with exposure incidents - Staff should be made aware of what to do when an exposure incident occurs. All exposure incidents should be reported immediately and staff should be immediately referred to a designated healthcare professional. There is post exposure prophylaxis (PEP) treatment available for both HBV and HIV but it must be taken soon after exposure. There is no PEP available for HCV. PSI 05/2007[25] sets out the Prison Service arrangements in England for the treatment of staff who may have been at risk of exposure to BBVs.

Post exposure treatment for HBV:
HBV immunoglobulin can be given after exposure to HBV to protect against transmission. Treatment following exposure to HBV should be given to all staff, whether vaccinated or not, as immunity to HBV may not be total. It is most effective given within 48 hours of exposure.

Practice Idea:

In addition to putting PEP arrangements in place with your main healthcare provider, contact your local casualty department to discuss arrangements for out-of-hours treatments.

9 Meeting the needs of staff

Post Exposure treatment for HIV:
PEP for HIV is currently available for those exposed to HIV through workplace accidents such as needle stick injuries. Studies have indicated that PEP can reduce the risk of contracting HIV by 80%. Treatment involves taking two to three pills a day for 28 days. There are severe side effects, including diarrhoea, headaches and vomiting. To be most effective PEP should be started within one hour of exposure but can be started up to 72 hours after exposure.

The recent PSI (05/2007) provides new mandatory instructions in relation to PEP for staff in England. Staff at risk of exposure need information on risks, the need to be assessed for PEP following possible significant exposure, and local arrangements for referral following such exposure. The PSI includes a draft letter for the member of staff to take with them to the occupational health or casualty department. You should consult with your local units to set up a protocol for referring your staff when required. This should ensure that staff are 'fast-tracked' given the need for timely administration of PEP.

Staff awareness – A Checklist

- Staff are given training on BBVs, including risks of transmission, prevention, PEP and treatment. ✓
- An HBV Immunisation programme is in place, with an identified administrator – all staff have initial appointment to discuss immunisation. ✓
- Staff are given information and training on stigma and discrimination faced by people living with BBVs, particularly HIV ✓
- Staff are given accessible, written information that reinforces verbal information. ✓
- Full risk assessments are carried out to identify risks of BBV transmission to staff. ✓
- A named individual is identified that staff can access in confidence for information or advice about the services offered. ✓
- Staff are given a BBV action card to ensure they understand what to do in the event of exposure. ✓
- A log is kept of all exposure incidents and action taken. ✓
- There are clear procedures in place for following up exposure incidents in order to learn from them. ✓

Key Resources

Health and Safety Guidance Note 02/2005 'Risk Assessment and Immunisation for Communicable Disease'

Annexe 9 to Guidance Note 02/2005 'Setting up an Immunisation Programme for HMP staff'

PSI 05/2007 [on PEP] Amendment to PSO 8900 – Occupational Health

HIV and Disability

From December 2005, HIV positive people are considered to have a disability according to the provisions of the Disability Discrimination Act 1995 from the moment of their diagnosis. This means that they enjoy the full protection of the DDA as a person with a disability. In addition, from December 2006, public bodies, including the prison service have to comply with the disability equality duty. This is a legal duty to take active steps to promote equality for disabled people, including people living with HIV. To find out more see the *Point of Diagnosis website*: www.pointofdiagnosis.org.uk and NATs guide: *HIV and Your Disability Equality Scheme*. www.nat.org.uk

10 Promoting health and equality

BBVs are not 'socially neutral' diseases – myths and beliefs can influence the way that people affected or at risk are treated. Discrimination or abuse related to BBVs, especially HIV, is often fuelled by ignorance about how BBVs are transmitted and/or prejudice against the groups most affected (in the UK, gay men, African communities, migrants and IDUs). This can be linked to homophobia, racism or anti-immigration sentiment. Whatever the cause, such discrimination has no place in society, and that includes prisons, and must be effectively dealt with in order to prevent:

- Unprofessional behaviour from prison staff acting on their prejudices rather than prioritising the welfare and rehabilitation of prisoners.
- Bullying and intimidation among prisoners, with affected prisoners excluded and victimised, also leading to discipline problems for staff.
- BBV-related discrimination against staff, potentially leading to work-related stress, absenteeism and ultimately disciplinary cases or legal action.
- Breaches of prison service policy, the law and prisoner's human rights (see side bar on prisoners' health and human rights).

Stigma and discrimination also hinder efforts to tackle BBV transmission and provide good quality healthcare. This is recognised in the practice codes of every major professional body governing healthcare in the UK. Why is tackling discrimination so important in relation to BBVs?

- Because effective healthcare is compromised when people at risk are afraid to come forward for BBV testing; missing out on advice about changing behaviour and access to treatment. Treatment not only saves lives but reduces infectiousness to others.
- Because stigma and discrimination create mistrust between patients and healthcare providers that can threaten therapeutic relationships beyond the provision of BBV-related care.
- Because stigma and discrimination are contrary to 'the whole-prison' approach to health promotion that every prison should be striving for (see below).

It is an oversimplification to suggest that stigma and discrimination are easily tackled but concrete actions can make a difference:

- *Review policy* – If necessary, update policies on equality and diversity, disability and healthcare to ensure that they include clear prohibitions against discrimination related to BBV or 'health status'.
- *Publicise the policy* – Prominently display anti-discriminatory statements using accessible language. Include specific reference to HIV and hepatitis.
- *Introduce genuine accountability* – Prisoners and staff need to know what to do if they believe discrimination has occurred. Wherever the complaint originates, investigation must be fair, independent and timely – **justice must not only be done but be seen to be done** if people are to have faith in the complaints system.

The Health Promoting Prison

As part of the 'decency agenda', prison service policy requires that all prisons work towards becoming 'health promoting prisons'. This recognises that 'health' is not something that healthcare practitioners alone create but is brought about by reducing health inequalities and attending to the broader social and environmental determinants of health. See:

Health Promoting Prisons: A Shared Approach
www.dh.gov.uk
The Health Promoting Prison
www.sps.gov.uk

- *Educate and inform* – Provide quality information for various prison audiences. Look for creative approaches. Can BBVs be integrated into broader prisoner education? Can staff use online resources rather than relying on logistically difficult training sessions? Remember, it is important to create safe opportunities to clarify information and explore attitudes and values.

Prisoner Health and Human Rights

International treaties on health and human rights create consensus and place obligations on signatory states to protect human health, including that of prisoners. While a full overview cannot be given here, some important provisions include:

- *The International Covenant on Economic Social and Cultural Rights* (Article 12) "the right of everyone to the highest attainable standard of physical and mental health."
- The *Convention on All Forms of Discrimination Against Women* (Article 12) "take all appropriate measures to eliminate discrimination against women in the field of healthcare."
- The *Convention on the Rights of the Child* (Article 24) "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."
- The *European Convention on Human Rights* places a duty to protect people in detention from 'inhuman or degrading treatment', which can include failure to provide adequate medical care (Keenan vs. UK 2001).[26]

11 Useful websites

National AIDS Trust	**www.nat.org.uk**
NAM	**www.nam.org.uk**
Hepatitis C	**www.hepctrust.org.uk**
British Liver Trust	**www.britishlivertrust.org.uk**

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Anne Norton, HM Prison Service
Adrienne Testa, Health Protection Agency

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www.sps.gov.uk

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www.bashh.org

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www.nat.org.uk/document/105

12. HM Prison Service (01/06/1999) PSO 3845 Blood Borne and Related Communicable Diseases

13. HM Prison Service (11/10/02) PSI 50/2001 Hepatitis C: Guidance for Those Working with Drug Users.

14. HM Prison Service (30/09/04) PSO 8900 Occupational Health

15. National AIDS Manual (2006) Living With HIV. London: NAM.

16. HM Prison Service (20/12/00) PSO 3550 Clinical Services for Substance Misusers

17. HM Prison Service (28/7/06) Clinical Guidance Note - Issuing Condoms to Prisoners

18. Home Office (2006) A Five Year Strategy for Protecting the Public and Reducing Re-offending. London: Home Office.
www.probation.homeoffice.gov.uk

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21. HMPS (2001) Getting It Right Together. Working with the Voluntary and Community Sector.
www.clinks.org

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13 Appendices

Appendix 1

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Appendix 2. BBVs – the Basics

Hepatitis B (HBV)

HBV is a blood borne virus that causes hepatitis (inflammation of the liver) and can also cause long-term liver damage. The incubation period is 40-160 days. During the acute phase of the illness following exposure many people may experience no symptoms while others may experience a flu-like illness including a sore throat, tiredness, joint pains, loss of appetite, nausea and vomiting. Acute infection can be severe causing abdominal discomfort and jaundice. Mortality during the acute phase of infection is less than 1 per cent. Failure to clear HBV infection after six months leads to the chronic carrier state. Many people who become chronic carriers have no symptoms and are unaware that they are infected. These individuals will remain infectious and will be at risk of developing cirrhosis and primary liver cancer.

The World Health Organization (WHO) estimates that in the UK the prevalence of chronic HBV infection is low, at around 0.3 per cent of the general population. However, HBV is more common in other parts of the world such as South East Asia, Africa, the Middle and Far East and Southern and Eastern Europe and due to the changing nature of immigration to the UK, there is marked geographic variation in the rates of HBV prevalence across the UK.

Transmission

The virus is present in bodily fluids such as blood, semen, saliva and vaginal fluid and is very infectious. Transmission routes are:

- Sharing injecting drug equipment, including spoons and filters.
- Sharing tattooing, acupuncture or piercing equipment.
- Unprotected sex.
- Contact with infected blood through an open wound, cut, scratch or bite.
- Mother-to-baby during pregnancy and childbirth.
- Improperly sterilised medical equipment.
- Needle-stick injuries.
- Blood transfusions and organ donation in countries where blood is not screened.[1]

Prisoners are identified as being at particular risk of HBV. This relates particularly to the high proportion of prisoners who have been (and/or are) injecting drug users. The last survey on rates of blood borne viruses in prisoners was conducted in 1998 and reported a HBV prevalence of 8 per cent among prisoners and 20 per cent among injecting drug users in prison.[2]

Vaccination

A vaccine is available and is 95 per cent effective at preventing infection from HBV in uninfected individuals.[3]

In prison settings it is recommended that the super-accelerated vaccination schedule be used (0, 7, 21 days), with the first dose

administered as part of the reception health check. The first dose of vaccine will afford some level of protection. However, it is important to complete all three doses, ideally with a booster vaccination at one year to ensure full protection. Blood tests before or after vaccination are not recommended in prison settings since prisons are considered a high risk environment for HBV infection and there should be no delay in vaccination. The HBV vaccine is very safe and there are no contraindications from receiving extra doses.

Prevention

- Get vaccinated.
- Keep cuts, scratches, bites new tattoos and open wounds clean and covered with a waterproof plaster.
- If any blood spills occur, clean with disinfectant appropriate for BBV hazard.[4]
- Never share toothbrushes, razors, scissors, hair clippers or other personal items that may come into contact with blood.
- Never share injecting drug equipment; this includes syringes, filters, spoons and water as well as needles.
- Use disinfectant tablets to clean injecting equipment, razors etc
- Never share tattooing, acupuncture or body piercing equipment.
- Always practice safer sex, i.e. sex with a condom.

Symptoms

Symptoms may not develop for up to six months and some people may experience no symptoms, yet still remain infectious. The main symptoms are:

- Nausea
- Vomiting
- Stomach ache
- Diarrhoea[4]
- Jaundice

If chronic HBV occurs, it can cause cirrhosis of the liver. Symptoms of this include:

- Internal bleeding, identified by vomiting blood or blood in the faeces (causing black, tarry faeces).
- Effects on the brain, such as loss of memory, slurred speech, confusion and unconsciousness.
- Fluid retention.
- Liver cancer.[4]

Diagnosis

HBV is diagnosed by a simple blood test.

Liver function tests can also be carried out to measure substances in the bloodstream that may indicate liver damage. A liver biopsy can be carried out to assess the extent of damage.

Treatment

Most people will recover from HBV without treatment. People who

develop chronic HBV will be monitored by a liver specialist to determine whether treatment is necessary. An antiviral treatment called *Interferon* is the main way of treating HBV. It prevents the virus from replicating and causing further liver damage.

Injections of the drug are given three times a week for at least three months, with the patient administering their own injections. *Interferon* is effective in 40 per cent of cases.[5] The treatment does cause side effects in many people, including sickness, headaches, fever, tiredness, muscle aches and depression. Regular check ups and blood tests are needed to monitor the side effects.

Another available treatment is *lamivudine*. This does not work in all cases and people can become resistant to it. It is taken in tablet form, once a day for at least a year.

In severe cases of HBV, a liver transplant may be an option; this is successful in 60-80% of people who are critically ill. The transplant does not cure the virus and the new liver will become infected, which can cause complications later.[6]

Hepatitis C (HCV)

HCV is a blood-borne virus that can severely damage the liver. Recent research has shown that HCV can also affect other areas of the body, including the immune system and the brain. The first six months following infection is called the acute stage and around 20 per cent of people clear the virus during this time without intervention. Most people, however, go on to develop chronic HCV.

Transmission

The main route of transmission for HCV is blood. It can be transmitted through:

- A small amount of infected blood getting into the bloodstream through, for example, an open wound, cut or scratch.
- Sharing injecting drug use equipment.
- Sharing straws or rolled notes etc for drug use.
- Sharing or using unsterilised tattooing, acupuncture or body piercing equipment.
- Sharing razors or toothbrushes.
- Mother-to-baby during pregnancy and birth. Breast-feeding is thought to be safe if the mother has no symptoms. Although if the mother has cracked and bleeding nipples and the baby has cuts in the mouth there may be a risk.
- Unprotected sex, specifically where blood or trauma are involved. Research has shown that transmission is rare but there is a growing number of gay men contracting HCV through sex, particularly if they are already infected with HIV and their immune system is weak. It is also believed to be more likely in sex with multiple partners, anal sex or where other sexually transmitted infections are present.
- Medical or dental work abroad.

Prisoners are identified as being at particular risk of HCV. This relates particularly to the high proportion of prisoners who have been (and/or are) injecting drug users. The result is that HCV prevalence was according to the most recently available data (1998) for England 7 per cent among prisoners and 31 per cent among injecting drug users in prison. [2]

Vaccine

There is currently no vaccine for HCV.

Prevention

- Keep cuts, scratches, and open wounds clean and covered with a waterproof plaster.
- If any blood spills occur, clean with undiluted household bleach/ appropriate disinfectant. [4]
- Never share toothbrushes, razors, scissors, or other personal items that may come into contact with blood.
- Never share injecting drug equipment; this includes syringes, filters, spoons and water as well as needles.
- Never share equipment for snorting drugs.
- Never share tattooing, acupuncture or body piercing equipment.

- Always practice safer sex, i.e. sex with a condom.
- Wash your hands after any incident involving blood, whether it is yours or somebody else's.
- Wear disposable rubber gloves if handling anyone else's blood or anything that may be contaminated with blood.

Symptoms

Many people have no symptoms and can remain undiagnosed for years. When symptoms do occur they can come and go and are often mistaken for other illnesses. Symptoms include:

- Fatigue
- Anxiety
- Weight loss
- Alcohol intolerance
- Loss of appetite
- Pain around the liver
- Concentration problems
- Sickness/nausea
- Digestive problems
- Flu like symptoms (fever, headaches, chills and night sweats)
- Jaundice.

There seems to be no relationship between the degree of liver damage and the experience of symptoms. The course of damage to the liver is also varied although it typically occurs slowly over 20 to 40 years: some people will progress to develop fibrosis and cirrhosis (scarring) of the liver, liver cancer or end stage liver disease, which may ultimately require a liver transplant, while others experience very little liver damage even after many years. Symptoms of end stage liver disease include:

- Internal bleeding, identified by vomiting blood or blood in the faeces (causing black, tarry faeces).
- Effects on the brain, such as loss of memory, slurred speech, confusion and unconsciousness.
- Fluid retention.[7]

Diagnosis

HCV is diagnosed through a series of blood tests. The first test looks to see if antibodies to HCV are present in the body, indicating that infection has taken place and the body is trying to fight the virus off. It can take up to six months before antibodies become present, the 'window period'.

If the first test is positive, a second test will take place on the same blood sample to confirm that antibodies are present. If this test is also positive a third test on a new sample may also take place. A positive result in these cases means that the person has been exposed to HCV at some point. It does not confirm if they are still infected or if the body has cleared itself of the virus.

To establish whether a person is still infected further tests must take place that look for the presence of the virus itself, rather than antibodies. If this comes back negative than the person has been infected in the past, but has cleared the virus and is no longer infected. If it is positive then they currently have HCV.[7]

Treatment

Not all people with HCV are considered suitable for treatment. In some cases patients are simply monitored to see whether damage to the liver is occurring or progressing.

Where treatment is advised, this is provided through combination therapy of two drugs: *Interferon* and *Ribavirin*. Interferon is given by injection, and patients must have either one or three injections a week (depending on which version they are prescribed) for six to twelve months. Ribavirin is taken orally, twice a day.

Treatment causes side effects in many. Side effects can include: anaemia, depression, fatigue, nausea, headaches and flu like symptoms. As a result of this regular monitoring and blood tests are required to monitor treatment and side effects. Treatment for HCV is very demanding and people undergoing it require a high level of commitment and support from others.

As with HBV, in severe cases a liver transplant is sometimes beneficial, although the new liver will become infected with HCV again.

All people with HCV require regular medical check ups by a specialist, whether they are receiving treatment or not.

HIV and AIDS

HIV stands for Human Immunodeficiency Virus. It is the virus that causes people to develop AIDS. HIV damages the body's immune system, making that person vulnerable to certain infections. Having HIV does not mean that you have AIDS. It may take several years for HIV to damage the immune system so much that a person becomes unwell. During that time a person with HIV can be well and live with the virus for many years without developing AIDS.

AIDS stands for Acquired Immune Deficiency Syndrome. A person is considered to have AIDS when the immune system has become so weak that it can no longer fight off a whole range of diseases with which it would normally cope. If HIV is diagnosed late, treatment may be less effective in preventing AIDS.

Transmission

HIV can be transmitted through bodily fluids such as semen, vaginal fluids, blood, and breast milk. It can be transmitted through:

- Unprotected vaginal or anal sex.
- Sharing injecting drug use equipment.
- Sharing tattooing, acupuncture or body piercing equipment.
- Mother-to-child, either during pregnancy, birth or through breast-feeding.
- Donated blood, blood products or organs in countries where these are not screened.

Vaccine

There is currently no vaccine available for HIV.

Prevention

- Always practice safer sex, i.e. sex with a condom.
- Never share injecting drug equipment. This includes syringes, filters, spoons and water as well as needles.
- Never share tattooing, acupuncture or body piercing equipment.
- Wear disposable rubber gloves if handling anyone else's blood or anything that may be contaminated with blood.
- Keep cuts, scratches, and open wounds clean and covered with a waterproof plaster.
- If any blood spills occur, clean with undiluted household bleach.

Symptoms

There are no specific symptoms for HIV, although some people may experience an illness after being exposed to HIV, this is called a 'sero-conversion illness'. Symptoms include:

- Prolonged fever (4 – 14 days) and aching limbs
- Red blotchy rash over the trunk
- Sore throat
- Ulceration in the mouth or genitals
- Diarrhoea
- Severe headaches
- Aversion to the light. [8]

The severity of symptoms varies between individuals and some may not develop any symptoms at all. All the symptoms mentioned can also be symptoms of other illnesses so their appearance should not be assumed to mean a person is infected with HIV. After this, people with HIV can live for years without developing any further signs of infection. As HIV suppresses the immune system, the body becomes vulnerable to opportunistic infections. These are illnesses that the body can usually recover from quickly but as the immune system is damaged they become more of a problem. Previously some of these illnesses were termed 'AIDS defining illnesses' and their appearance resulted in a diagnosis of AIDS. However, with the advent of treatment, the idea of AIDS defining illnesses becomes less useful. A person can be diagnosed with AIDS, receive treatment, and recover. For more information on the stages of HIV infection go to www.nam.org.uk.

Diagnosis

HIV is diagnosed through a blood test, which checks for antibodies to HIV. If antibodies are present it shows that the person has been infected. After a positive result, further tests can be done to measure the level of HIV in a person's blood and whether they need to start treatment to contain the virus.

Treatment

Treatment for HIV, called antiretroviral treatment (ART), is available and slows the development of HIV in the body, ensuring people stay healthier for longer. Treatment regimes usually involve taking several different pills a day and can have significant side effects. These can include:

- Nausea/vomiting
- Headache
- Fever
- Fatigue
- Diarrhoea
- Fat redistribution
- Loss of appetite
- Skin rashes
- Flatulence
- Pancreatitis[9]

When taking treatment for HIV it is important the drugs are taken at the right dose, right time and in the way prescribed by the doctor (for example, some drugs must be taken without food, some with high fat food). If the treatment regime is not followed properly, for example if a break in treatment occurs, the HIV inside the body can develop resistance to the drugs and the treatment will fail. Even missing a few doses or taking them late can be critical.

13 Appendix 2 References

References

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7. +VE (2004) A rough guide to Hep C, Middlesex: How's That Publishing

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13 Appendix 3 Offender Pathway Diagram

ENTRY

Reception: 24hrs – 1 Week
Aims – 1) Identify prisoners at risk for potential follow-up, 2) get immediate treatment to those who need it, 3) commence HBV vaccination programme.

Actions – Reception
Use reception health screen to identify those at risk and provide ongoing BBV medication to those prescribed it prior to imprisonment.

Actions – Induction
Provide basic information about: 1) BBV risks, transmission and treatment, 2) HBV Vaccination, HBV/HCV/HIV testing and treatment services, 3) anti-discriminatory policy, 4) named individual(s) for further information, 5) policy on access to condoms and disinfectant tablets.

All prisoners offered HBV vaccination on super-accelerated schedule (0, 7, 21days)

Phase 1: One Month or Less
Aims – 1) Continue HBV vaccination, 2) initiate follow-up of prisoners identified at risk.

Actions – 1) HBV vaccination schedule continued 2) raise awareness of BBV testing, 3) those on medical treatment for BBV infection under specialist care, 4) all prisoners requiring it under clinical substance misuse care and CARATS support, 5) all prisoners requiring them given regular access to condoms and/or disinfectant tablets.

Phase 2: Two to Five Months
Aims –1) Enable prisoner to make informed appraisal of risk, 2) enable prisoner to access voluntary BBV testing, 3) establish secondary care treatment pathways where required, 4) enable prisoners to practice ongoing risk reduction.

Actions – 1) Provide opportunity for individualised discussion with healthcare professional on personal BBV risk, 2) offer voluntary BBV testing and provide result(s), 3) arrange secondary care referrals as appropriate, 4) provide ongoing access to condoms and disinfection tablets.

Phase 3: Six Months Plus
Aims –1) Ongoing medical treatment and care for those infected, 2) ongoing risk reduction for those at risk of infection who are currently BBV negative or of unknown BBV status.

Actions – 1) Stable treatment relationships established for infected prisoners with secondary care services, 2) social/psychological support for those infected regarding living with a long-term condition, 3) ongoing access to condoms and disinfectant tablets, 4) ongoing access to information and advice on personal risk reduction (including HBV vaccination for those not previously covered by initial super-accelerated programme).

Resettlement Planning
Aims –1) Integration of BBV-related issues into resettlement planning.

Actions – 1) Integrate awareness of BBV related needs into planning for accommodation, employment, training/education, family/social support, 2) provide assistance in identifying and registering with a GP in the community, 3) where possible, liaise with secondary care providers in advance regarding imminent release, 4) ensure CARATS referral to community substance misuse services where necessary, 5) arrange adequate supplies of medication to cover transitional arrangements, 6) sign-post to local and national BBV related support services.

RELEASE

Appendix 4: Useful Policy Documents

England and Wales

HM Prison Service (01/06/1999) PSO 3845 Blood Borne and Related Communicable Diseases

HM Prison Service (11/10/02) PSI 50/2001 Hepatitis C: Guidance for those working with drug users

HM Prison Service (20/12/00) PSO 3550 Clinical Services for Substance Misusers

HM Prison Service (23/10/2003) PSO 3200 Health Promotion

HM Prison Service (29/05/02) PSI 25/2002 The Protection and Use of Confidential Health Information in Prisons and Inter-agency Information Sharing

HM Prison Service (15/06/2002) PSO 4190 Strategy for Working with the Voluntary and Community Sector

HM Prison Service (2004) Performance Standards - Health Services for Prisoners

HM Prison Service (30/09/04) PSO 8900 Occupational Health

HM Prison Service (05/2007) PSI 05/2007 Amendments to PSO 8900 Occupational Health

All of the above available from *www.hmprisonservice.gov.uk*

HM Prison Service (02/2005) Guidance Note on setting up an immunisation programme for HMP staff.

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Scotland

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Scottish Prison Service (2005) The Direction of Harm Reduction in the SPS. From Chaotic Drug Use to Abstinence. Edinburgh: Scottish Prison Service.

Scottish Prison Service (undated) Health Needs Assessment. *www.sps.gov.uk*

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Scottish Executive (2005) Respect and Responsibility Strategy and Action Plan for Improving Sexual Health. Edinburgh: Scottish Executive. *www.scotland.gov.uk*

Northern Ireland

Northern Ireland Prison Service (2005) Standing Order 10: Health Care *www.niprisonservice.gov.uk*

Northern Ireland Prison Service (2005) Standing Order 1: Reception, Removal and Discharge *www.niprisonservice.gov.uk*

Northern Ireland Prison Service (2006) Policy on Alcohol and Substance Misuse *www.niprisonservice.gov.uk*

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