HEALTH NEEDS OF OLDER PRISONERS

With specific reference to HMP Whatton
By
Dr Ann-Marie Stewart
BACKGROUND TO PRISON MEDICINE 1

• 1996- Sir David Ramsbotham, HM Chief inspector of prisons stated:
‘prisoners should be entitled to the same level of healthcare as provided in society at large. Those who are sick, mentally ill or disabled should be treated, counselled and nursed to the same standards demanded within the NHS’
BACKGROUND TO PRISON MEDICINE 2

• In response – task forced established in 2000

• 2003 – initiation of responsibility transfer from Ministry of Justice – due to skills decay, poor morale and tension between medicine and discipline

• 2006- prison healthcare became responsibility of PCTs
AIM

.... To demonstrate the challenges we face in achieving the aims of Sir David Ramsbotham, especially in relation to older prisoners

....With specific reference to HMP Whatton which has one of the oldest prison populations
WHAT CONSTITUTES AN OLDER PRISONER

• Clear conflict between physical appearance and chronological age

• Studies in US suggest prisoners have physical health of 10 years older than community contemporaries

• Aday (1994) and Wahidin (2002) and AgeUK recommend 50+......not recognised by NOMS
REASONS FOR THE AGEING OF PRISONERS

• PREVIOUS LIFESTYLE: chaotic lifestyle, high degree of homelessness, poor access to healthcare, poor diet, addictions

• PRISON LIFE: Thomas, USA (2005), ‘stress of incarceration accelerates ageing through lack of support systems in a chronically stressful and debilitating environment’
RISE IN OLDER PRISON POPULATION

REASONS FOR RISE IN ELDERLY IN PRISON

• 1. ‘greying’ of existing population as we incarcerate more each year and give longer sentences

• 2. historical crimes- especially sexual crimes: increased by 45% between 2002 and 2012

• 3. indeterminate sentences (IPP)
HEALTH NEEDS OF OLDER PRISONERS

• Data not routinely collected by MoJ or NOMS

• 2004 – HM Inspector of Prisons published a report:

  ‘NO PROBLEMS: OLD AND QUIET’

which criticised the lack of care of older prisoners.
## HEALTH NEEDS-PHYSICAL

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>35%</td>
<td>51%</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>24%</td>
<td>51%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>15%</td>
<td>27%</td>
</tr>
</tbody>
</table>

60–64 | 65–69

HEALTH NEEDS - MENTAL

Study in HMP Stafford:

51% of 50-59 year old had at least one psychiatric disorder
42% in those >60

Fazel (2001) – rates of depression in older prisoners are about 3x higher than equivalent age and gender in the community.
## Mental Health problems (Brooker 2007)

<table>
<thead>
<tr>
<th>Mental Health Disorder</th>
<th>Prisoners</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality disorder</td>
<td>64%</td>
<td>3-5%</td>
</tr>
<tr>
<td>Any neurotic disorder</td>
<td>40%</td>
<td>18%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>20%</td>
<td>4%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>20-30%</td>
<td>2%</td>
</tr>
</tbody>
</table>
HEALTH NEEDS-DEMENTIA

• No published accurate rates
• Estimates from Justice Committee reports suggest 5% in >65s – speculative
• Royal College of Psychiatrists suggest dementia rates approx 1% (=community)
• Prison regimen may make its recognition harder
• 6-cit used in all over 65s IN HMP Whatton – 2 diagnoses of dementia (both vascular)
HMP WHATTON
HMP Whatton

- Category C prison
- Capacity 841 men
- Index offence is sexual
- Age range 21-83 (our eldest was 93)
- 105 inmates are >65 years old
- One of the oldest populations of any prison
- Of the >65s, 48% smoke, and 36% are obese, 93% take prescription medicaments
HMP Whatton

Co-Morbidities for Over 65’s. Includes Cancer diagnoses but not Obesity or Smoking.

Number of co-morbidities per patient

<table>
<thead>
<tr>
<th>Chronic Diseases</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Chronic</td>
<td>17</td>
<td>23</td>
<td>22</td>
<td>21</td>
<td>13</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Disease</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

BGS Spring Conference 2015
Incidence of chronic disease in >65s in HMP Whatton

Chronic diseases

- Asthma: 15
- COPD: 6
- Cancer: 12
- CKD >3: 20
- Dementia: 2
- Diabetes: 27
- Heart Failure: 5
- Hypertension: 66
- Obese: 38
- PAD: 7
- Rh Arthritis: 2
- 2o Prevention: 29
- CVA/TIA: 13
## Comparative Prevalence of chronic disease

<table>
<thead>
<tr>
<th>Condition</th>
<th>WHATTON</th>
<th>EBMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>32%</td>
<td>5.0%</td>
</tr>
<tr>
<td>AF</td>
<td>5.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>DIABETES MELLITUS</td>
<td>26%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>
# Physical disability in HMP Whatton

<table>
<thead>
<tr>
<th>Disability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced mobility</td>
<td>25%</td>
</tr>
<tr>
<td>Hearing difficulties</td>
<td>24%</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>12%</td>
</tr>
<tr>
<td>No disability recorded</td>
<td>10%</td>
</tr>
</tbody>
</table>
Challenges in provision of equal care:
1. Prison environment and disability
..contd

• Fabric of prison estates varies: older prisons pose problems for wheelchairs etc; there is no nursing home placement or specialist facility

• NOMS is required to promote equality under DDA 2005-section 3-which states that reasonable adjustments must be made

• 2013 –MoJ report stated that ‘many older prisoners are currently being held in establishments that cannot meet their needs’
HMP Whatton
Cell for disabled prisoners
HMP Whatton
Dementia suite
2. Social care

• Social care needs of older prisoners can be significant
• MoJ report 2013 ‘sparse, variable or non-existent’
• Possibly greater need than in community to conform to prison regimes
• Often left to other prisoners e.g wheel-chair pushers, bringing meals, make beds
Social care continued

• New arrangement from 1/4/2015-social care of prisoners, in whose area a prison is located, formally became responsibility of local authority

• Estimate of cost is £8.6m, £6.4m of which is for >50s
3. Hospital visits

- Hospital visits are often stressful

- Shackled to prisoner officers and waiting in public waiting rooms

- High levels of refusal to attend for investigations of planned procedures
4. Bullying

- Many prisons have high levels of abuse of prescription medicaments e.g. tramadol and gabapentin often by younger in-mates

- Appropriate prescribing in elderly can lead to bullying for these medicines

- Some elderly prefer to avoid medicines for their pain so not victims of bullying
5. Prison/healthcare interface

• Can impact in number of ways:

• ‘Old and quiet’ has been a term applied to older prisoners - often ignored with attention on those with more challenging problems

• Institutionalisation and prison regimen – means dementia may not be recognised-and low dementia diagnosis rates in prison
Prison/healthcare interface continued

• High turnover- often inmates moved to another prison at short notice – so hospital appointments can be missed (although medical hold often applies)
What is done well?

1. End of life care

- Majority of deaths in custody between 2007 and 2010 were in >55 age group
- Palliative care suites more frequently found to facilitate end-of-life care
- Report in 2013 showed 54% died in hospital, 30% in prison and 15% in hospice
- This broadly reflects community statistics
- Family visits often facilitated
Palliative care suite at HMP Whatton
Palliative care suite 2
2. Use of restraints

- Prison Ombudsman have reported historically inappropriate use of restraints in ill prisoners in hospital
- Despite their age, some older prisoners can still be considered to be a significant risk to the public
- Conflict between public protection and respect for dignity of patient
- Increased dialogue between healthcare staff and senior prison officers in making decisions
3. Variation to prison regimes

• ‘wing buddies and pad-pals’ to assist and report problems to healthcare

• Disability helpers

• ‘over 50s’ gym sessions

• Dedicated older prisoners wings-with specific activities or longer ‘unlock periods’
4. Healthcare

- Named nurses
- Chronic disease managed in same way as community
- Falls assessments as standard on admission
- ‘Older prisoner’ template completed on admission, looking at hearing, vision, vaccinations
- In HMP Whatton, dementia screening with 6-CIT
- Appointment with GP within one week of admission
Healthcare continued:

• New Leaf services
• ‘Lighter side of life ’ weight management programme
• Recently audited all obese patients and offered referral for bariatric surgery for those eligible under NICE guidelines
• Physio and OT services
• Hepatitis vaccination policy
• Access to sexual health and substance misuse services if appropriate
5. National Screening policy

AAA Screening

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible*</td>
<td>105</td>
</tr>
<tr>
<td>Screened to date</td>
<td>57</td>
</tr>
<tr>
<td>Normal result</td>
<td>56</td>
</tr>
<tr>
<td>Abnormal Result</td>
<td>1</td>
</tr>
<tr>
<td>Awaiting Screening</td>
<td>48</td>
</tr>
</tbody>
</table>

NB: Eligible figures include all those who can self refer for screening.

Currently struggling to find NHS numbers for 2 patients without which screening cannot take place.
NB: Screening programme not currently running. Stopped from local hub due to problems with the process of screening in a custodial environment.
What next?

• Specialist units for the older disabled prisoner

• Adoption of national quality standards equivalent to QOF in the community

• Commissioning of more in-house specialist services or telemedicine to reduce need for hospital attendances
Finally...

• I hope you have gained an understanding of the high disease load of our older prisoners and some of the reasons behind this

• How we often face particular challenges to achieve the same level of care as in the rest of the community

• With particular thanks to Julie Cox and Kay Bywater-Pinto in provision of data for this presentation
THANK YOU!

....and any questions?