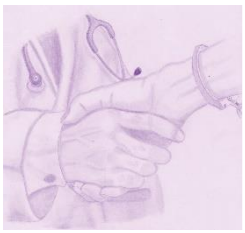

QNPMHS and RCGPSEG Joint Webinar:

COVID-19 in prisons, 9 April 2020

Recording:

https://www.rcpsych.ac.uk/improving-care/ccqi/resources/ccqi-webinars

Guidance discussed:

RCGP Guidance for healthcare in secure environments

RCPsych COVID-19 Secure hospital and criminal justice settings

Questions and Answers:

The following questions were posed throughout the webinar. The speakers, Caroline Watson (CW), Pamela Taylor (PT) and Mika Rautanen (MR), have provided responses.

Please note, the answers provided are subject to change as the situation progresses. Please continue to check for new guidance and advice on COVID-19 in this setting.

1. **Can the college consider providing recommendations to look at a national roll out for Buvidal for Opiate Replacement Treatment for Prison leavers?**
2. **Buvidal is an injectable formulation of Buprenorphine that can stay in the system for as long as a month**

PT: The College and/or prisons network would be open to considering this. There is, however, NICE guidance on its use – with prisoners as well as others – and it might be hard to improve on this without further research.

https://www.nice.org.uk/advice/es19/resources/opioid-dependence-buprenorphine-prolongedrelease-injection-buvidal-pdf-1158123740101

The position is that a single RCT with 428 people of the injectable slow release vs sublingual buprenorphine-naloxone found no advantage for the injectable slow release version, which is much more costly. However, it is acknowledged that the slow release form may have an advantage in some populations. We need a trial among prisoners! In the special circumstances of having to deal with COVID-19, the advantage is that the prisoner/patient would have to be seen less frequently if needs were solely addiction related but would need to see a clinician at least monthly for the injection.

Participant comments on topic:

I am working in a large central London prison. I agree with the opiate replacement issue. It would be good to have a mandate to be able to dispense espranor or dispersible OST or injectible buvidal. titrating methadone is complex owing to physical health problems.

(FYI, injectable Suboxone ('Sublocade') has been available in Canadian federal prisons and on release (Unverified) asked "I have to go now, but thanks very much!")

One of the issues about buprenorphine (non-espranor or buvidel) in my prison is the provider only dispenses crushed which means people need to wait around the hatch which staff are concerned increases risk of COVID transmission

3. **Remote working? do you mean, seeing patients using vide-link or phone calls? this is already happening in Canada, two of our British Trained Forensic Psychiatrist in Kingston Ontario, previously my colleagues in Notts HC, are doing this , including assessments treatment etc**

PT: Yes, we do mean using video-link preferably, or phone calls it that is all that is available. We would strongly advocate using is to help clinical work for the duration of the COVID-19 crisis, while being alert to the problems that may accompany such use. I have seen the Canadian system in action, in Ottawa, and it is hugely impressive for quality. Further, as Canadian clinicians – and clinicians in other countries with prohibitive distances to travel – have considerable experience, a lot of excellent thinking has gone into how to manage such assessments optimally and ethically.

I would recommend that everyone using such equipment in the UK at present in relation to prisoners, documents what they have been doing in that respect and the positives and negatives of the experience. Once the COVID-19 crisis is over, we need to have a major review of the situation, and make recommendations on the basis of as much information and experience as possible.

My prediction is that we will certainly want to use it more as tool in future. It will be a particular advantage for example, when multiple clinical assessments are called for as clinicians strive to find the right level of service. If, for example, one clinician saw the prisoner face to face for an extended assessment, but anyone else who needed to do an assessment could do so by video-link, that could improve efficiency, reducing running costs substantially. Scarce resources like psychotherapy might be made more available.

There are several issues that would need to be considered, however, before introducing this as routine. What would be the cost of rolling out good quality equipment prison service wide (along Canadian lines)? Cheapest bid solutions are likely to cost more in the long run and be questionably ethical.

What standards of privacy could be expected in such interviews – routine prison staff monitoring of clinical interviews would not be acceptable.

What would be the right balance of video-linked interviews and interviews in person? It is essential that clinicians keep visiting the prison estate and seeing for themselves the conditions in which the prisoners are being held – this is impossible from the comfort of the consultant's office when the prisoner is brought to a purpose designed interview suite.

Participant comments on topic:

If anyone wants to know more about video-link please email younus.saleem@nottshc.nhs.uk, I was the first UK forensic psychiatrist to do gate keeping assessments and court reports using video-link into prisons 15 years ago. Since then I have also used video-link to conduct full length forensic assessments into hospitals and community. Happy to advise anyone who wants to do this.

PT: Excellent news – but it will still be the case that we should have a full review of this once the COVID-19 crisis is over. The issues are about so much more than successful use of technology.

4. **In context of a national, standardised response would a prison environment be classed as a Community Model or Secondary Care Model given that the approaches to care are very different as well as overlap e.g. Emergency Response?**

   CW: Primary Care (for physical health)

   PT: The general rule is that if a person would be receiving care and treatment in the wider community – as a primary care patient or secondary care out-patient – then it is acceptable, where possible, for their treatment to be delivered in prison for the duration of any court requirement that they must stay there. In psychiatry this is, therefore, generally acceptable. In other areas of medicine, where particular technology may be required, then even out-patient secondary may have to be delivered in hospital and so the prisoner taken out.

   Anyone who needs a secondary or tertiary care inpatient bed needs transfer to a designated hospital. If enforced treatment for mental disorder is required then the patient must be transferred as a matter of urgency. Medication may be enforced in prison only as a bona fide emergency – so once, maybe twice in any particular episode – when in doubt, clinicians should consult with their defence union and College. So, prison in-reach medicine will mainly follow a primary care model, with some occasional and limited outpatient secondary care.

5. **Are MHA transfers from prison to secure hospital still happening?**

   PT: We do not have any figures, but there is no reason why they should not be. Some limited and temporary reform of mental health legislation is to cut bureaucracy rather than options. There is, however, a potential problem in staffing hospital beds, so transfers may be even slower than usual. Please let us know of any special problems in this regard and we can at least take them up with government health departments.

   Participant comments on topic:

   In terms of security, the local remand prison is allowing new staff to commence work in the absence of the vetting process

   One of the challenges we have had is regarding PPE - owing to different providers in the prison there are different guidelines from the providers, as well as from the prison itself.

6. **In terms of security, the local remand prison is allowing new staff to commence work in the absence of the vetting process**

   CW: This reduced level vetting has been agreed as part of the pandemic workforce planning. It allows quick access and more flexible arrangements to facilitate adequate staffing e.g. for those who usually work in community or those returning from retirement.

7. **One of the challenges we have had is regarding PPE - owing to different providers in the prison there are different guidelines from the providers, as**

well as from the prison itself.

CW: PHE PPE guidance was updated 02/04/2020 for healthcare workers. Further clarity around PPE for prison staff is anticipated, including around use in RCU/SU.
There has (since this webinar) been published guidance for PPE use in healthcare and prison staff. This will be attached as an appendix in the RCGP guidance update.

8. **We found your suggestion around supporting prisoners' families interesting. How do we approach this in practice?**

   CW: Inside Time will be running an article on healthcare with reference to COVID-19 (and around the RCGP guidance) in the May edition. It would be useful to set up a more interactive way of supporting prisoners' families – perhaps offering a webinar. Jake Hard RCGP gave an interview on national prison radio, answering questions posed by Listeners in prison. As the pandemic evolves and the arrangements in prisons across the UK evolves, advice will change and questions will evolve. It would be good to provide an interactive and repeating opportunity to address questions from both prison residents and their families.

   PT: We can try and ensure that prison staff are making prisoners and their families aware of government guidance on the matter – this is available at:
   https://www.gov.uk/guidance/coronavirus-covid-19-and-prisons

   and includes a list of voluntary organisations which have committed to offering at least helpline support to families:
   Prisoners' Families Helpline
   Partners of Prisoners and Families Support Group
   Prison Advice and Care Trust (PACT)
   Prison Reform Trust

   When we are more involved directly with prisoners we can ask them to help their families make these connections if they have not already done so. In a few cases we may judge that, clinically, there may be a case for more direct intervention if, for example, vulnerable children are involved.

9. **Finally, we are having to do an awful lot of work where we need to do face to face through cell hatches which is very difficult for confidentiality, however it is difficult to see alternatives to this at the moment. I don't know if you have any suggestions about this.**

   CW: Telephone access would improve communication although I take the point about confidentiality. I think this is a potential area for working with HMPPS to develop confidential telephone access to healthcare so that this could be taken forward in future – possibly for triaging purposes (community equivalence in mind)

   PT: First we need to be sure that the necessary physical protection is in place – appropriate face masks for prisoner and staff.

   This also will interfere with communication, but is essential for the rather close facial contact in such circumstances.

   The most important thing is to remind the prisoner of the limits to confidentiality in such circumstances – it may seem obvious, but people who are ill enough to be seen in

cells may not pay much attention to this.

Be ready to steer the interview away from potentially damaging disclosures in the circumstances, making a note so that it is possible to return to the issues, if possible and appropriate, when circumstances improve.

Encourage prison officers, and even other prisoners, to work with us in respecting confidences where appropriate. Prisoners are involved in confidential work through the Prisoners' Listener Service and many prison officers are highly professional and able to work in appropriate partnership in such circumstances.

Participant comments on topic:

Thanks for your answer in relation to video-link, agree that there is no real substitute to f2f, but these are extraordinary times, I am doing my ward rounds and clinics here in a low secure unit using video link and Microsoft teams - works, patients are grateful

I am one of those UK psychiatrists working in Kingston Ontario. We are actually forbidden from going physically into the prisons due to COVID-19 because of the perceived risk of us bringing the virus into the prison (even though we have many fewer cases per capita than the UK). Authorities over have a different view of risk management - prioritising reducing the spread over normal mental health care, but least the video link facilities are good

Scotland haven't yet started early releases. One of my concerns is about the ability of people to adapt to changes in the "outside" on release. In addition to this, the difficulty accessing face to face support (different agencies), prescriptions, seeing family and housing. I'd be grateful for any advice on this. Thanks.

Although they have telephones within the cells in the prison where I work, most cells are shared. I am concerned about discussing confidential matters with inmates - although they themselves have generally not complained.

Reluctance to use video-link will put lives at risk - no two ways about that

10. Scotland haven't yet started early releases. One of my concerns is about the ability of people to adapt to changes in the "outside" on release. In addition to this, the difficulty accessing face to face support (different agencies), prescriptions, seeing family and housing. I'd be grateful for any advice on this. Thanks.

CW: My understanding is that early release is only approved if there is housing provision arranged (in England). We have had only a very small number meeting the early release criteria where I work because the requirements are (necessarily) stringent.

11. Although they have telephones within the cells in the prison where I work, most cells are shared. I am concerned about discussing confidential matters with inmates - although they themselves have generally not complained.

CW: Good point. Could timings be arranged for appointments when cell mate gone for shower or phone call? I think unlikely, but again worth considering how we can make this work well.

12. Should we wear PPE as a matter of routine when visiting inmates in their cells? - just the mask or mask/apron/visor?

CW: PHE has (since the webinar) issued guidance for PPE in prescribed places of detention, for both healthcare and prison staff. This will be an appendix in the updated RCGP COVID-19 guidance for healthcare in secure environments.

PT: This is not really a question for psychiatrists, but I think the concept of 'routine' is the key. If it really is routine because the only reason for seeing a prisoner in his/her cell is because all are isolated as a precaution, then gloves, masks, goggles, washable clothes and apron may be sufficient. Bear in mind that hard surfaces in particular may hold the virus for up to 72 hours, and prisons are generally not the most cleaned places. If there are good grounds for suspecting the prisoner has COVID-19, then in my view, full PPE may be more appropriate, but especially the facial coverage as interviews which are at least semi-confidential in such circumstances require close face-to-face proximity.

13. How can confidentiality be preserved when phone calls are monitored in the prison?

PT: Unless a commitment is agreed that clinical calls will be confidential, then it can't. Even with such a commitment, I would recommend caution. We should ask lawyers how they are managing this – they might have some good advice.

14. **Is there any evidence which shows that prison healthcare is not as good as in the community?**

PT: I am not aware of any direct research comparisons. To get an answer to this, we would have to be sure that we were really comparing like for like in terms of patients as well as healthcare. For example, there is an argument that many prisoners would get terrible health care in the community because they have poor links with necessary facilities and fluctuating motivation and/or that some services may be prejudiced when it comes to delivering care and treatment to chaotic people with multiple morbidities. Conversely they might actually get better health care in prison, less because the care is any different, but because they are being held to it. The whole point of healthcare in prison being provided by in-reach services made up of clinicians who are embedded in the NHS or other recognised healthcare provider is to ensure that, as far as possible, care is equivalent – at least delivered to the same standards as it would be in the community. This is back, though, to whether a prisoner has mainly primary healthcare needs of more. There is certainly evidence that there have been serious health care omissions and even avoidable deaths because there were insufficient prison staff to get a particular prisoner to necessary investigations or more complex treatments.

Participant comments on topic:

As far as I understand, prisoners can see GP, Psychiatrist & CPN much quicker than general community outside prison. The same for ADHD assessment and treatment. For specialist medical appointments, some specialists visit prison, otherwise they can go straight to hospital bypassing A&E and has treatments ASAP for security reasons and send back to prison.
We have managed to divert inmates from a prison more quickly than usual (4 in less than a week)- perhaps because MSUs and PICUs are concerned that they would be unable to admit in the following days/weeks.

We are using NEWS 2 for our covid-19 patients. A drop in BP seems to be a common part of their condition. This causes a significant rise in the NEWS 2 score that worries the Healthcare staff, probably unnecessarily. We are linking the NEWS 2 score to the patient's overall health - how ill are they.

PT: It would be excellent to think that there might be one or two health advantages for this generally health-compromised population. We do need to be careful that we have good evidence of differences. Much of what is reported is either local or transient and largely anecdotal – including, as indicated, what we can say as a College on this point.

15. We are using NEWS 2 for our covid-19 patients. A drop in BP seems to be a common part of their condition. This causes a significant rise in the NEWS 2 score that worries the Healthcare staff, probably unnecessarily. We are linking the NEWS 2 score to the patient's overall health - how ill are they.

CW: NEWS2 is recommended when a patient appears to be unwell or deteriorating. It is a good indicator for sepsis (Covid-19 related or otherwise) and is widely used in primary and secondary care – therefore is a good 'language' of communication to hospitals/ambulance crews. The drop in BP, rise in heart rate, rise in RR and temp are all part of the NEWS2 score and all part of the sepsis picture.

16. Is it possible for the College to issue advice on how we might be more readily able to treat patients on healthcare wings for mental disorder against their consent when they lack capacity i.e. as one would do under the MHA. This is in the context of delays in transfer to secure hospitals.

PT: There has been no softening of the line that medication may be given without consent in a bona fide emergency, but not otherwise. Of course some judgement is required on what constitutes a psychiatric emergency in such conditions, but there is not much leeway for good reasons. On top of any ethical issues powerful pharmaceuticals have side effects, including toxic effects, and need close clinical monitoring for safety, especially when a patient is highly aroused and or taking illicit substances.

17. During ACCT reviews officers are not wearing PPE should we as nurses attending the reviews be wearing a mask?

CW: If you are within 2m of the patient (and you are likely to be as you will be having a conversation) then a mask (and apron and gloves) recommended. I think we can lead the way as health professionals and also it may help prison residents to understand that we take their health seriously.

PT: This may depend to an extent on the distancing possible during such reviews. If close face to face interviewing is required I would say that prisoner and assessor should wear a mask and goggles unless there is a strong psychiatric contraindication – for example that the patient is so disoriented or deluded that this could create more danger in the situation.

18. We have had more overdoses since IP medication was introduced. Surely an alternative to IP should be considered for psychiatric patients, to reduce overcrowding during medication times (for instance having 4 inmates out a time standing 2 metres apart as in supermarkets)?

CW: Bringing small groups out at a time for medication is definitely an option, if there is staff capacity. The IP option is when staffing levels become critical (or when infection levels rise and therefore medication either needs to be done at the patient's door or needs to be kept IP).

PT: Appropriate clinical assessment informed treatment plans remain as essential as they ever were. If IP medication is truly inappropriate for a particular patient, it is inappropriate, COVID-19 or not.

19. Another observation is if they need psychiatric admissions they for to secure hospitals which has much better accommodations, facilities, comprehensive MDT than mainstream mental health services. A lot of mainstream inpatient psychiatric units have discharged their patients and cleared their beds and had to give those to general hospitals as they need more beds for physical health.

PT: There are two parts to this question –

Secure hospital services may well be better equipped, but they are likely to be full, with no prospect of releasing patients because they tend to pose serious risks to others in the community. So, this is unlikely to be more than an occasional solution.

Inpatient psychiatric units should almost certainly not be giving in to pressures to clear their beds – it may even be that as part of this crisis there is more call for them. It is already the case that a disproportionate number of patients are admitted compulsorily to general psychiatric beds. The President has been making representations to make the continuing need for psychiatric beds clear. If members have evidence that psychiatric patients are being abused by being denied the inpatient services they need then it is important to contact the College with that evidence.

20. Do you think IAPT is considered an essential service in UK prisons? and should their services continue given this crisis?

PT: This is probably not a question that can be given a general answer. In some cases the service may be essential, in some cases it may be possible to defer it. Consideration should be given on a case by case basis to deferring any treatment which could safely be deferred.

21. What about inmates on ADHD medication and need BP checking when we are undertaking telephone interviews?

CW: If you had a nurse on site who was willing to check BP (or even train up peer health champions to do this, it would work – though not very well during Covid-19 because of risk of infection transmission).

PT: In countries with well-established telemedicine it is possible to get blood pressure readings transmitted. Treatment plans should be adjusted to allow for what is safe and acceptable if safety checks are limited.

22. One of the issues about buprenorphine (non-espranor or buvidel) in my prison is the provider only dispenses crushed which means people need to wait around the hatch which staff are concerned increases risk of COVID

transmission

CW: It would be good to see whether the provider would be willing to obtain Espranor oro-dispersible which would be quicker dissolved.

23. Would it be advisable to have cases screen by the psychiatrist so those only with urgent/complex need can be placed for face to face review?

CW: I think that this could be a good use of resources, (equivalent to senior clinician doing physical health care triaging)

PT: This could be trialled – it might work well, but there are obviously risks too. The psychiatrist could use a recognised screening checklist and then check, say, ten cases at random for the first week to determine the accuracy of the approach. An underlying question may be how much screening has already taken place and how reliable and valid that is.

24. Could Mika say more about what and how information is shared with prisoners?

MR: Local Health care staff meets local Criminal Sanction Agency staff regularly and listens to needs and every-day questions arising from prisoners. Print info sheets are delivered to wards and for those prisoners able to use prisoner intra web there are information links such as: https://www.rikosseuraamus.fi/fi/index/portti/terveysjahyvinvointi/korona/coronavirusinformationforprisoners.html.

Prisoners can also voluntarily report if they belong to certain named risk groups. Notification says for instance: "Please familiarise yourself with the list of risk groups below. If you feel that you belong to one of the risk groups, tick the box next to the group on the list. Then, return the form in the enclosed envelope to the outpatient clinic if you agree that Criminal Sanctions Agency may be informed that you belong to a risk group for the purpose of making possible changes to your residence. Remember to enter your name and social security number on the form. By returning this form, you grant permission to inform Criminal Sanctions Agency that you belong to a risk group. The only information provided by the outpatient clinic is that you belong to a risk group. No detailed health information, such as medical records or medication, is disclosed." Prisoners then get more information from Health care concerning and based on their condition.

25. Outreach services from the hospitals has stopped - e.g. heptology clinics. how quickly can remote access be available?

CW: Our prison is taking orders of webcams in the coming days. Re-hepatology – this could be done with a phone conversation. We are (and have been for a while) working with distance support from hepatology teams. We do the bloods and (if we have access to the shared fibroscanner) do a fibroscan on site in the prison. We then send the blood results, a completed referral form and patient consent form to the hospital who discuss it as an MDT and advise on (and provide) medication via homecare pharmacy service to the prison. We then manage the patient's 12 weeks of treatment in house and do monitoring bloods. The hepatologist is happy to treat with blood marker for fibrosis (ie even without fibroscan result).

PT: This sounds risky – but beyond our pay grade!

26. Has everyone read the excellent article about the 1918 pandemic in San Quentin?

https://www.jstor.org/stable/pdf/4575142.pdf?refreqid=excelsior%3Aa35175730e00eef2f4d702054542c62d