

TRANSFORMING  
THE UK'S  
RESPONSE  
TO HIV



# TACKLING BLOOD-BORNE VIRUSES

A framework for prisons in the UK





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# 1. Introduction

## 1.1 Who this framework is for

This framework is a practical resource supporting action on blood-borne viruses (BBVs) for people involved in the health and wellbeing of people in prison in the UK. It is aimed primarily at healthcare staff based in prisons but may also be relevant to others involved in the management of prisons and the wellbeing of people in prison.

Prison governors, others involved in senior management of the prison or on the prison's Partnership Board should look at Section 5.

## 1.2 Why BBVs are important

BBVs are a serious public health concern. If undiagnosed and untreated they can cause severe illness and even death, yet they are preventable and treatable diseases. Prisons are not isolated institutions and failing to respond effectively to these BBVs puts everyone at risk; prisoners, their families and the wider community. **This framework looks at Hepatitis B virus (HBV), Hepatitis C virus (HCV) and Human Immunodeficiency Virus (HIV).**

There is a much higher prevalence of these BBVs in the prison population than the general population.<sup>1</sup> In England, among those tested between 2008 and 2012, Hepatitis C antibodies were found in 14% of the prison population compared to 3% of the general population.<sup>2</sup> A Scottish study from 2011 found Hepatitis C prevalence amongst the prison population to be 19%.<sup>3</sup> This is because some people in prison are particularly vulnerable to BBVs. Providing education and information on prevention in prisons is important as practices which increase the risk of BBV transmission - sharing injecting equipment, unprotected sex and tattooing - continue to take place in prisons.

It is essential that people in prison have the opportunity to test for BBVs given the high number of people living with undiagnosed infections; those with a

positive result have the right to access the equivalent high standard of care as their peers in the community.

### Box 1: Prisons and drug use

Levels of drug use amongst people in prison are high. In 2014, nearly two thirds (64%) of people in prison in England and Wales reported using drugs in the four weeks before custody. Two thirds of women and more than a third of men (38%) reported committing offences to generate income to buy drugs.<sup>4</sup>

In Northern Ireland in 2014, almost 40% of people in prison reported that they had a problem with drugs when they came into prison.<sup>5</sup> In Scotland in 2012, 73% of people in prison tested positive for illegal drugs on admission to prison and more than 43% reported using illegal drugs whilst in prison.<sup>6</sup>

As the possession of injecting equipment is strictly prohibited in prisons, those who inject are likely to share any injecting equipment they acquire. The 2015 Scottish Prison Survey found that of those who had injected drugs in prison in the last month, 82% had shared injecting equipment.<sup>7</sup>

## 1.3 Four areas for action on BBVs in prisons

### 1. Prevention outcomes

- People in prison understand what BBVs are, how they are transmitted and how this can be prevented.
- People in prison have access to the means to prevent BBV transmission (e.g. access to condoms and disinfecting tablets).

## 2. Testing outcomes

- Prisons have implemented opt-out BBV testing so that all people in prison have the opportunity to test for BBVs and to access treatment and care.
- All staff delivering opt-out BBV testing have sufficient training and support to deliver testing and other appropriate treatment and care.
- Accessible information is available in the prison about BBV testing and what the results mean.

## 3. Treatment and care outcomes

- People in prison receive care equivalent to people in the wider community and in line with professional standards and local and NICE guidelines and quality standards.
- People in prison have access to high quality, confidential, primary care services, with expertise in BBVs.
- People in prison have access to high quality, confidential secondary care, which should include: hepatology services, genitourinary medicine (GUM) or infectious disease medicine, substance misuse treatment, mental health services and social support.
- People in prison do not experience interruptions to care if transferred or on release to the community.

## 4. Stigma and discrimination outcomes

- Prisons provide up to date, relevant education that challenges myths about BBVs, corrects misunderstandings and stresses the importance of confidentiality.
- Prisons have policies and practices that ensure that discrimination related to BBVs is not tolerated, and measures in place to prevent and respond to it.

1. *Frequently asked questions to support the opt-out BBV testing policy*, PHE, 2014
2. *Annual Report of the Chief Medical Officer's Surveillance Volume 2012*, Department of Health, 2014
3. *Hepatitis C Prevalence and incidence among Scottish prisoners and staff views of its management*, NHS Health Scotland, 2012
4. *Bromley Briefings: Prison the facts*, Prison Reform Trust, Summer 2015
5. *The safety of prisoners held by the Northern Ireland Prison Service*, Criminal Justice Inspection Northern Ireland 2014
6. *Hepatitis C Prevalence and incidence among Scottish prisoners and staff views of its management, 2012*, NHS Health Scotland
7. *Prisoner survey 2015*, Scottish Prison Service, 2015

## 2. The prison pathway

This section will look at what actions should be taken as part of a prison's BBV response throughout a person's experience within the prison using a **five stage prison pathway** as a model. It identifies where BBV interventions should happen throughout a person's experience within the prison and provides more details on each intervention.

### Key guidance documents

NICE has produced guidelines [Physical health of people in prison](#) (2016) which is the key document prisons should refer to. NICE has also published guidelines on [Mental health of adults in contact with the criminal justice system](#), which provides information on assessment and management of mental health and wellbeing in the prison setting.

For more detailed information on prescribing medicines in prison and on transfer, please see the Royal Pharmaceutical Society [Professional standards for optimising medicines for people in secure environments](#) (2017).

For more information on the Hepatitis B vaccination please refer to Chapter 18 of [the Green Book](#).

The Hepatitis C Trust document [Guidance: Hepatitis C prevention, diagnosis and treatment in prisons in England](#) contains more detailed information relevant to Hepatitis C and on the implementation of opt-out BBV testing in prisons.

### A. Reception and healthcare induction (custody period of 24 hours to one week)

Reception and induction can be difficult for many people and especially those in prison for the first time. People are given a lot of information on arrival and so it is important to be selective about what

BBV interventions to provide. However, for remand and short-stay prisoners, this is one of the best opportunities to start work on BBVs.

### Reception

Every person must undergo reception health screening as recommended within NICE guidelines.<sup>8</sup> This presents an important opportunity to identify those already being treated for BBVs. It is important to identify a BBV diagnosis and ensure continuity of treatment and care.

For those taking HIV or HCV treatment, continuity of treatment must be an urgent priority for reception health screening. If HIV treatment is to be effective, it is important that it is taken at the right time and in the way prescribed by the doctor.<sup>9</sup>

If there is a break in treatment, HIV and HCV can develop resistance to the drugs and the treatment may fail.

As well as the health implications, treatment disruption is likely to cause unnecessary distress. Prisons should have the following in place:

- A clinical protocol outlining what to do if a person has a BBV diagnosis including referral to specialists (e.g. an HIV specialist) as soon as possible but no later than one month after arrival.
- Immediate access to supplies of ART to ensure continuation of treatment.
- Fast referral to an HIV specialist if there is any change or interruption in treatment.

Prisons should also consider a protocol outlining what to do if a person reports that they are currently taking Pre-Exposure Prophylaxis (PrEP is an HIV prevention

treatment regimen; see the Appendix for more information). For example, prisons should be aware of where it is possible to access PrEP locally and should have in place referral links to these sexual health services should a person wish to continue to take PrEP when in prison.<sup>10</sup>

## Healthcare induction

Prisoners usually receive a further healthcare induction. This is referred to in the NICE guidelines as the second stage health assessment and should be used to provide the following:<sup>11</sup>

- Information on BBV prison-related risks such as sharing injecting equipment, tattooing and sex without a condom. Any information provided should be accessible, considering the needs of those with young reading ages or learning difficulties.
- Information on the prevention tools available in the prison (e.g. condoms, disinfecting tablets, Post-Exposure Prophylaxis and dental dams) and where to find them. It is also useful to identify a named individual that people can speak to in confidence for information or advice about the services offered in the prison.
- The offer of HBV vaccination and BBV testing (as recommended by NICE guidelines) and information about sexual health clinic services. BBV testing should be offered on an opt-out basis (see **Box 2: Opt-out BBV testing and Case Study 1: Opt-out BBV testing in HMP Pentonville**). Details on the vaccination schedule for HBV can be found in Chapter 18 of the Green Book. This includes information on accelerated and super-accelerated schedule for HBV vaccination.

HBV vaccination for those over 18 can be completed in 21 days using a super-accelerated schedule. Young offenders aged under 18 can be prescribed the super-accelerated schedule on an individual basis. Where this is not possible, the accelerated schedule should be used.

- Those who are not registered with the NHS should be encouraged to do so and receive their unique NHS number to ensure continuity of care.

Induction is also an opportunity to make clear the importance of healthcare confidentiality and that discriminatory behaviour related to BBV status will not be tolerated. The goal is to create a climate where those at risk feel able to access healthcare services and support.

### Box 2: Opt-out BBV testing

Despite the high prevalence of BBV infection, people in prison have traditionally been under-tested. Before 2010, less than 4% of the English prisons' population had been tested for BBVs. To improve this, a partnership agreement between Public Health England (PHE), NHS England and the National Offender Management System (NOMS) introduced a national 'opt-out' testing policy in adult prisons in 2014. The importance of testing all prisoners was underlined in the 2016 NICE guidelines on the Physical Health of People in Prisons.

The 'opt-out' element is essential. Evidence from HIV ante natal screening shows that opt-out testing is an effective model, normalising the testing process. Verbal consent should be sought but rather than asking the prisoner if they would like BBV testing, the prisoner is told that all prisoners are tested for BBVs, unless they say that they do not wish to be tested.

Dried blood spot testing is recommended for this setting. It is easy to administer and less invasive than venepuncture, which may be difficult for prisoners with a history of injecting drug use. Where a patient's test result shows HCV antibodies, the same sample should be used for PCR testing to test for active infection and so full results can be given to the patient at one time (see Appendix on HCV basics for further information). Those who refuse a test should be re-offered testing throughout their stay.

Post-test discussion should be carried out with every patient regardless of the results. If the results

are negative, this is an important opportunity to provide information about how to protect yourself from BBVs.

The Scottish Government has committed to deliver opt-out testing across the whole Scottish prison estate.

In Wales opt-out testing was introduced across all prisons in November 2016. Treatment for anyone testing positive is provided within each prison by visiting Hepatology teams or integrated sexual health services from the local Health Board.

There is currently no policy for opt-out BBV testing in prisons in Northern Ireland.

The Hepatitis C Trust published guidance in 2016 that aims to assist prisons with the implementation of opt-out testing. It includes a checklist for commissioners.<sup>12</sup>

**See Case Study 1: Opt-out BBV testing in HMP Pentonville.**

### B. Phase one (custody period of two months or less)

BBV interventions can be a challenge for those working with remand and short-stay prisoners because of the limited time available. Many will spend a month or less in prison. Even for those in prison for a short time, the following is essential:

- Those already receiving BBV treatment must have their treatment maintained and be under the care of a specialist consultant.
- Everyone should be offered opt-out BBV testing (this will hopefully have happened at induction). Those with a new diagnosis should be referred to secondary care and should have had the opportunity to discuss whether they wish to begin treatment with relevant healthcare providers.
- Those requiring it should be receiving substance

misuse support. This should include maintenance therapy where clinically indicated and harm minimisation advice that includes information on BBVs.

- HBV vaccinations should be completed (on a super-accelerated schedule). This should include information on how a person can complete vaccination and receive a booster in the community if released before completion.
- Everyone should have access to condoms (see **Box 3: Condoms in prison and Case Study 2: Condom provision in Scotland's prisons**), lubricants, dental dams and disinfecting tablets and information about how to access sexual health services.

### Box 3: Condoms in prison

Prisoners need access to condoms, as well as lubricants and dental dams, if they are to practise safer sex and protect themselves from HIV and other STIs. Policies on the provision of condoms vary across the UK. In England, Scotland and Wales, prisons must provide condoms, lubricant and dental dams. Prisons in Northern Ireland are not currently required to provide condoms.

Her Majesty's Inspector of Prisons raised concerns about variable access to condoms in 2012 as part of the Commission on Sex in Prisons (the Howard League for Penal Reform). Concerningly, one prison had told inspectors that access to condoms was unnecessary as none of the people in the prison were 'homosexual'. In some prisons condoms and lubricants were widely available, placed in discreet places or distributed to prisoners, whereas in others condoms were only available on request.<sup>13</sup>

**See Case Study 2: Condom provision in Scotland's prisons**

### C. Phase two (custody period of one month onwards)

For those in prison for longer periods of time there are more opportunities for intervention. During this phase:

- Provide further opportunities to test for BBVs at least once a year and on request. Guidelines also recommend more regular testing for those at higher risk, for example, men who have sex with men who have multiple partners are recommended to test for HIV every three months. However, in prison risk behaviours may not be reported. Information should be made available explaining when testing is recommended and that HIV tests are available if requested.
- For those with a positive result, treatment relationships with HIV and/or hepatology specialists should be established.
- Those on treatment should be supported to manage their medication. Prison pharmacists can assist by developing drug administration protocols and advising prisoners on adherence. Care must be taken to ensure that medication administration does not lead to disclosure of a person's BBV status. Wherever possible, in-possession medication should be encouraged if this is what the prisoner wants.<sup>14</sup>
- Ongoing psychological support should be provided to those managing a BBV;<sup>15</sup> this should include access to peer support if possible and may be provided through local community organisations.
- Risk reduction advice should be given to all and all should have access to condoms, lubricants, dental dams and disinfecting tablets.

### D. Transfer

The prison population is highly transient in nature. BBV-related needs must be integrated into planning for transfer. Key factors to consider include:

- Is it in the person's interests to suggest a 'medical hold'?
- For example, people in prison accessing twelve-week Hepatitis C treatment courses have been put on medical hold until the completion of their treatment. Ask the person's Hepatitis/HIV clinician for their view on the medical advisability/timing of transfer, giving them at least 24 hours' notice to

provide advice.

- Is the person's medical record up-to-date regarding BBV-related needs/treatment?
- How will any outstanding BBV test results be communicated following the move?
- How will the need for outstanding HBV vaccinations be communicated following the move?
- If the prisoner is taking complex medication, have arrangements been made with the new prison to continue this without treatment disruption?
- Are there measures in place to ensure that confidentiality around BBV status is not compromised and that information is shared only as appropriate and necessary.
- Once considered, actions should be put in place to address any issues raised by the above. This should include contact with the new prison in order to ensure communication of relevant information.

### E. Resettlement

Resettlement is a complex area of offender management. In addition to general resettlement needs, some will have specific BBV-related needs. The importance of pre-release health assessments for prisoners with complex needs was underlined in the NICE guidelines. It's important that before release prisoners are:

- Registered with the NHS and have an NHS number to ensure continuity of care.
- Supported to identify a GP in their new area of residence.
- Assured of continuity of BBV-related clinical care through liaison between prison and community healthcare services. Secondary care providers in the community should be notified of planned release.
- Given adequate supplies of medication to cover the transitional period. People leaving prison are normally given a minimum seven days prescribed

medicines or an FP10 prescription.<sup>16</sup> It may be appropriate to give more than this. 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.

- Assured of continuity of mental health and emotional support initiated in prison via effective liaison between prison and community healthcare services.
- Referred to community drug treatment teams that can offer harm minimisation approaches in the community, including needle exchange.
- Signposted to local and national telephone helplines and crisis services, including those specifically offering services to people living with BBVs.

### Box 4: Meeting performance indicators in England

Health and Justice Indicators of Performance (HJIP) were introduced in England in 2014 to monitor the quality and performance of healthcare in places of detention. Public health indicators have been developed for tuberculosis, HBV, HCV, HIV, sexual health and communicable disease control. The measures set out in this framework should support prisons to meet performance indicators relating to BBVs.

The BBV indicators state that healthcare teams in prisons and other places of detention should:

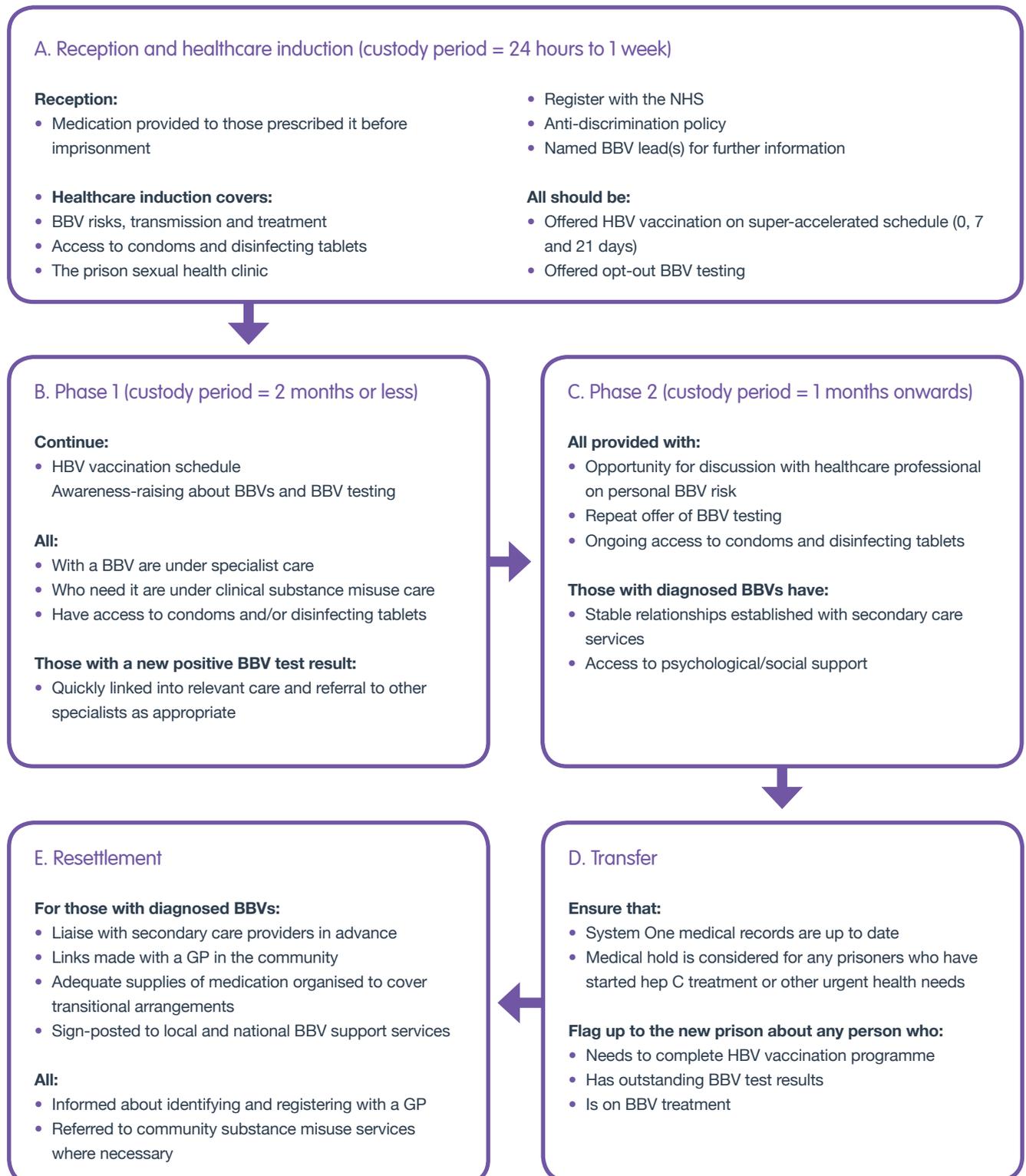
- Achieve HBV vaccine coverage of over 80% for all eligible prisoners/detainees received into the establishment within four weeks of arrival.
- Ensure all prisoners/detainees are tested for HBV, HCV and HIV within four weeks of arrival.
- Ensure that all those with an HCV antibody positive test are automatically tested for PCR (polymerase chain reaction) within four weeks of arrival.

- Ensure all prisoners/detainees testing positive for HBV and /or HCV are referred to the specialist service immediately who should assess them within 12 weeks of referral.
- Ensure all prisoners/detainees testing positive for HIV are referred to the specialist service immediately who should assess them within two weeks of referral.
- Ensure prisoners and detainees are given advice and information around BBV prevention and able to access condoms, lubricants, disinfectant tablets and a range of preventative educational materials around BBVs.
- Ensure prisoners and detainees are given advice about options for treatment and information on how to link up with community services on release.

Prisons may consider working with community organisations to facilitate resettlement. See **Case Study 3: Prison Link Project: Supporting people living with Hepatitis C on release from HMP Barlinnie** for a project in Scotland working to ensure successful continuity of treatment for people leaving prison diagnosed with HCV.

8. For more information on questions that can be used in the initial health assessment on reception in prison see Table 1 in section 1.1 'Assessing health' in NICE Guidelines *Physical health of people in prison*, 2016
9. Please see *Professional standards for optimising medicines for people in secure environments*, Royal Pharmaceutical Society, 2017
10. PrEP is available through the NHS in Scotland and Wales. In England the NHS currently funds access to PrEP for eligible persons through the PrEP IMPACT Trial. For more information on the trial and participating clinics go to <https://www.prepimpacttrial.org.uk/>. PrEP is not currently available on the NHS in Northern Ireland.
11. See 1.1.13 to 1.1.31 in the NICE guidelines *Physical health of people in prison* (2016).
12. Guidance: Hepatitis C prevention, diagnosis and treatment in prisons in England, Hepatitis C Trust, 2016.
13. Commission on Sex in Prison, Consensual sex among men in prison, Briefing Paper one, the Howard League for Penal Reform, 2013
14. For more detailed information please see *Professional standards for optimising medicines for people in secure environments*, Royal Pharmaceutical Society, (2017).
15. Please see NICE guidelines *Mental health of adults in contact with the criminal justice system* for more information on assessment and management of mental health and well-being.
16. For more detailed information please see *Professional standards for optimising medicines for people in secure environments*, Royal Pharmaceutical Society, (2017).

## 2.1 The prison pathway: quick checklist

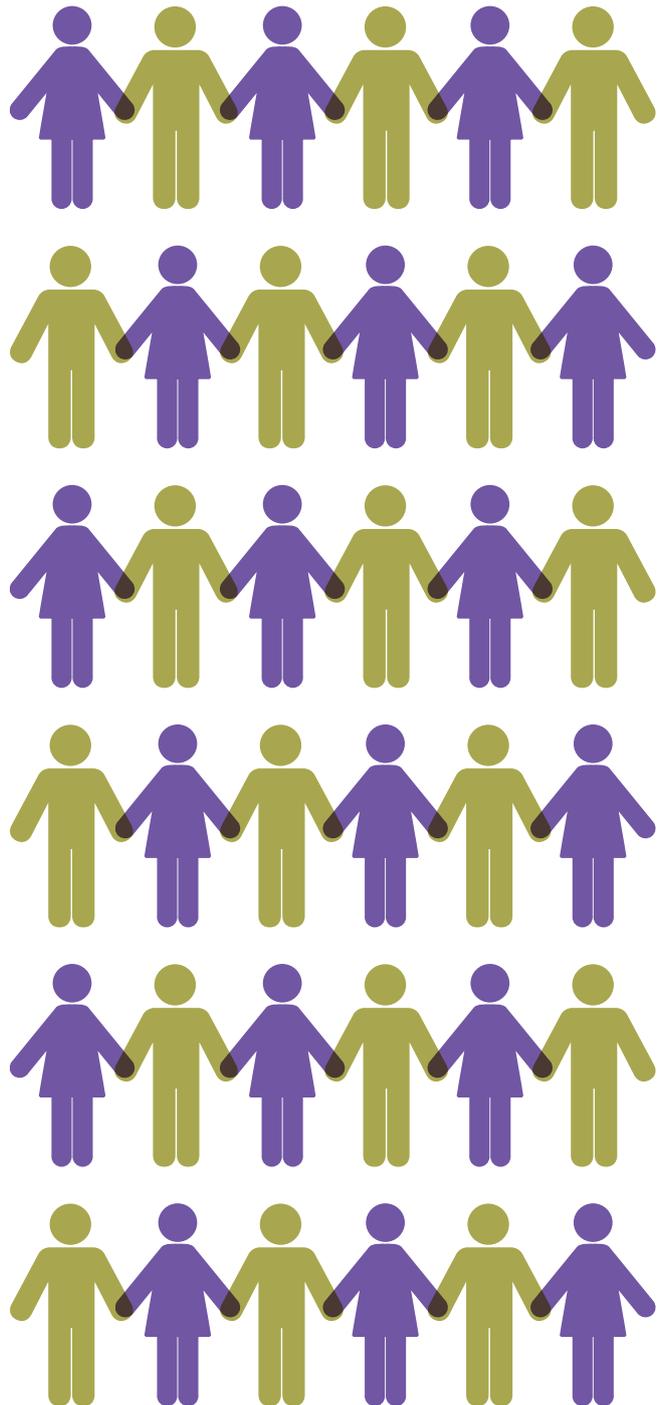


### 3. Working with community partners

External agencies play a vital role in prison work. It's important to look at the organisations working in your prison and make sure some with specific BBV expertise are included. CLINKS has an online directory of organisations working in prisons: <http://www.clinks.org/directory>.

There are some specific things to consider when developing partnerships with BBV organisations. For example, the stigma attached to BBVs means support organisations will be concerned about client confidentiality and how this is safeguarded in a prison environment. Therefore, discussion of how to maintain a balance between observing confidentiality and the expectations of prisons regarding disclosure of information will be needed. This should secure mutually acceptable arrangements for ensuring prisoners can access in-reach services confidentially.

For examples of how some prisons have worked with external organisations or have used external resources see **Case Studies 3: Prison Link Project: Supporting people living with Hepatitis C on release from HMP Barlinnie, 4: LASS at HMP Leicester: Cascading knowledge on BBVs throughout the prison, and 5: BBV awareness training in prisons in Northern Ireland.**



## 4. Meeting the needs of prison staff

This section should be read in conjunction with prison health and safety and occupational health guidance. There is a legal obligation to look after the health and safety of all prison staff and this includes reducing the risk from BBVs.

### Key guidance documents

There are a range of important guidance documents on infection control in prisons available on the Public Health England website. These will also be useful for prisons outside England.

<https://www.gov.uk/government/collections/public-health-in-prisons>

The Health and Safety Executive guidance on Blood-Borne Viruses in the work place should also be referred to.

<http://www.hse.gov.uk/pubns/indg342.pdf>

### 4.1 Training

All staff should receive basic BBV training so they can identify transmission risks and how to prevent them. There is basic information on BBVs in the Appendix which may be useful to prison staff.

Advanced training can include additional information about living with BBVs, from treatment to the stigma and discrimination faced by some people. Bringing in people from external organisations working with people with BBVs is a very effective way to deliver training. See section 3 for more information on working with external community partners.

### 4.2 Prevention

The risk of BBV transmission from prisoners to staff is extremely low. All staff should be made aware of health and safety procedures which includes the use of universal precautions. Proper use of universal

precautions, such as wearing disposable gloves when handling anything contaminated with blood, will prevent transmission of BBVs.

An immunisation programme should be set up to minimise the likelihood of HBV transmission to staff. All staff at risk of exposure should be offered immunisation. The programme should be monitored, audited and reviewed - so careful record-keeping is also essential.

### 4.3 Dealing with exposure incidents

Staff must be made aware of what to do when an exposure incident occurs. All exposure incidents should be reported and staff should be immediately referred to a designated healthcare professional within the prison.

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.

The prison should:

- Provide staff with information on risks, the need to be assessed for PEP following possible exposure, and local arrangements for referral following such exposure.
- Put PEP arrangements in place with your main healthcare provider and ensure that there is a clear procedure in place for following such arrangements in a timely manner following an exposure incident.
- Contact your local Accident and Emergency department to discuss arrangements for out-of-hours treatments and ensure that staff are aware of any alternative arrangements.

### 4.4 Staff awareness checklist

1. Staff are given training on BBVs, including risks of transmission, PEP, treatment and stigma and discrimination.
2. A HBV immunisation programme is in place and all staff have an initial appointment to discuss immunisation.
3. A full staff BBV risk assessment has been carried out.
4. A named individual has been identified who staff can speak to in confidence for BBV advice and staff are informed who this person is.
5. Staff are given a BBV action card so they understand what to do in the event of exposure.
6. A log is kept of all exposure incidents and the action taken.

## 5. Tackling stigma and discrimination

Stigma and discrimination is still a significant issue for many people affected by BBVs and is a barrier to prevention, testing and treatment. Stigma is often linked with ignorance about how BBVs are transmitted and/or prejudice against the groups most affected. For example, in the UK, HIV disproportionately affects gay men and African communities whilst Hepatitis C disproportionately affects people who have injected drugs. Awareness of stigma and discrimination and action to address these is very important in successfully implementing an effective approach to BBVs in prisons.

Discrimination has no place in prisons and must be dealt with effectively to prevent:

- Bullying and intimidation.
- Unprofessional behaviour from prison staff and breaches in medical confidentiality.
- Breaches of prison policy, the law and human rights.
- Barriers to effective healthcare with prisoners reluctant to test for BBVs, access prevention tools or treatment.

Stigma and discrimination are not easily tackled but concrete actions can make a difference. The following actions should be considered. Some of these will likely require buy-in from staff from outside the healthcare team and these may need to be discussed within the prison governance structures (see Section 6).

1. **Review policies** – If necessary, update policies on equality and diversity, disability and healthcare to ensure that they include information about discrimination related to BBV or health status.
2. **Publicise policies** – Prominently display anti-discriminatory statements using accessible language. Include specific reference to HIV, HCV and HBV.

3. **Introduce genuine accountability** – People in prison 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.
4. **Educate and inform** – Correcting myths and misconceptions about transmission routes is important. Provide quality information for various prison audiences and look for creative approaches.

### Box 5: BBVs and equality law

HIV is defined as a disability in the Equality Act 2010 and Disability Discrimination (Northern Ireland) Order 2006. This means that people living with HIV are protected by law from the point of diagnosis, and discriminating against someone living with HIV is unlawful.

Although HBV and HCV are not covered by law from the point of diagnosis, if these conditions have a substantial and long-term adverse effect on someone's ability to carry out normal day-to-day activities, someone living with HBV or HCV is considered to be disabled and would also be protected from discrimination by the same legislation.

Public bodies in England, Scotland and Wales, including the Prison Service, must comply with the Equality Duty. This is a legal duty to take active steps to promote equality for disabled people, as well as those with other protected characteristics. Public bodies in Northern Ireland, including the Prison Service, must meet the Disability Equality Duty. This is a legal duty to promote equality for disabled people.

## 6. Leadership and accountability: Action on BBVs beyond the healthcare team

In order to effectively implement this framework, buy-in, support and leadership is needed throughout the prison. This needs to go beyond the healthcare team so that this team is supported to deliver on the main points outlined in the prison pathway. This section is aimed at Governors and other senior staff within the prison.

Prison governors drive the strategic direction of the prison and are accountable for meeting the needs of their prison population. This includes wider responsibilities for the health and protection of the prison population. In the future, as the agenda for prison reform develops, this may also include co-commissioning responsibilities for health services within a prison. Governors should consider how the prison's approach to BBVs fits within the wider activity of the prison and should work with their staff teams to alleviate any barriers to implementation of action against BBVs.

The prison leadership team should consider the following to support the health team in their approach to BBVs:

### 6.1 Appointing an accountable senior BBV lead

This person should be accountable to the senior management team and/or prison partnership board and should:

- Take personal responsibility for ensuring action is taken in the four areas for action - prevention, testing, treatment and stigma and discrimination (See 1.3 for more information).
- Identify and agree with prison leadership key

outcomes and assemble the right team to take work forward to meet these.

- Ensure the team has the seniority and resources to make decisions and implement them.
- Ensure prison staff have training on BBVs, the opt-out testing process and how to care for people with BBVs. This should be reviewed annually to ensure that staff are up to date on treatment advances.
- Take a personal interest in monitoring results and report outcomes to the senior team and to the wider prison staff.

### 6.2 Ensuring a joined-up approach

Responsibility for BBVs in prison is shared between many partners. BBV leads need to involve the following in delivering a response:

- Commissioners
- Custodial staff
- Healthcare staff and prison pharmacists
- Substance misuse workers
- External health and social care services (including voluntary and community organisations)
- Domestic violence workers
- People in prison (and/or their advocates)
- Probation.

### 6.3 Developing a BBV policy

A written policy helps set out your aims and actions to tackle BBVs and gives staff who come across any issues related to BBVs an easy reference point. This need not be long. Existing policies can be updated or elements of other policies incorporated or signposted to, for example, health and safety, drugs, equality or confidentiality policies. National guidance is available and your policy should take account of this.

#### What could a BBV policy include?

- Basic facts about how BBVs are transmitted, prevented and treated, and why prisons must respond effectively.
- The aims and objectives of the policy, how it will be monitored and updated, and 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.
- Appropriate occupational health policies and practice.
- Measures to support and advise prisoners and staff living with BBVs.
- Measures to support continuity of care into the community.
- Policy statements on confidentiality, non-discrimination and respectful treatment.
- Whistleblowing policy to support reporting if bad practice or discrimination is observed.
- Sources of further information and advice.

## 7. Case studies

### 7.1 Opt-out BBV testing in HMP Pentonville

HMP Pentonville is a remand prison with capacity for 1,300 people. The prison implemented opt-out BBV testing in December 2015. A project lead is responsible for the implementation but all nursing staff have been involved and are engaged with the programme.

Most prisoners are open to the offer of testing. In the period between December '15 and December '16, 48% accepted testing. This equates to 1143 out of 2379 total offered. The prison has found that a large number of prisoners who refuse the tests give the reason that they have been tested elsewhere.

Patients that have tested positive for either Hep B or Hep C have been seen by a member of the nursing staff for further testing and discussion. During this period 18 patients tested positive for Hepatitis B, and a further 92 patients tested positive for HCV. Some of these patients knew of their diagnosis prior to arrival and these were confirmation tests. These patients are referred to a nurse specialist at Royal Free London Hospital where they are discussed at a multi-disciplinary team (MDT) meeting where a decision is made on further assessment and treatment. Following discussion at MDT a total of 6 patients began treatment as of December 2016.

One of the main difficulties in implementing this pathway is having to work in the constraints of the prison. For example, over the reporting period of December 2015 to December 2016, the prison experienced major difficulties in providing the published regime due to a severe lack of operational staff. This led, for extended periods, to reduced access to prisoners. To compound this, the prison experienced two major incidents in October and November 2016 which meant the prison was 'locked down' for a number of days after each incident.

### 7.2 Condom provision in Scotland's prisons

Since 2007, it has been policy in Scotland for prisons to provide condoms and dental dams to prisoners. This followed a successful pilot in 2005. Prisons have provided condoms and dental dams in a variety of ways:

- Via vending machines
- Distribution by healthcare or addiction case worker staff
- By appointment with a doctor
- Via the C Card scheme.

Prison staff were initially concerned about condoms being used to smuggle or conceal drugs and about safe disposal of used condoms. So far these concerns have not proved justified and the schemes have worked well. Most prisons now allow prisoners to dispose of condoms in normal waste as they were not accessing the service when special collections or biohazard bags were provided.

Uptake is higher where access to condoms is more anonymous or discreet. Having to approach a staff member or apply for a C Card are immediate barriers to access. Free and open access to condoms and lubricant, either via vending machines or baskets filled and replenished by health staff, are more likely to be successful.

### 7.3 Prison Link Project: Supporting people living with Hepatitis C on release from HMP Barlinnie

A prison link project launched in Autumn 2016 by the charity Waverley Care supports prisoners diagnosed with HCV with their transition and continued treatment upon release from HMP Barlinnie. The project aims to equip people leaving the prison with the resources to

allow them to better manage their health, clear HCV and move forward with their lives.

Prisoners who have been diagnosed with HCV can often access treatment while in prison. However, many former prisoners fall out of contact with healthcare services upon their release. This presents particular challenges for prisoners who transition back into the community during treatment, and those who may not have commenced treatment in the first-place due to their imminent release.

Waverley Care provides a holistic programme of support before, during, and after their release. A dedicated Prison Link Worker helps individuals to plan for liberation, making sure the right support is in place to address the practical issues, like accommodation, benefits and access to recovery services, that prevent people from following through with their treatment. Following release, service users are also linked in to Waverley Care's community services to provide continued support.

In the first half of 2017, the AbbVie funded pilot worked with 24 individuals at different stages of their journey. Following release, over 90% of service users remained in contact with the Prison Link Worker, with many of them now preparing for or commencing treatment.

## 7.4 LASS at HMP Leicester: Cascading knowledge on BBVs throughout the prison

LASS (Leicestershire AIDS Support Services) worked collaboratively with the Healthcare Centre Manager and Head of Diversity at HMP Leicester, a remand prison, to raise awareness and understanding about HIV, HBV and HCV with prisoners and staff and to set up services to support those diagnosed with HIV.

LASS aimed to give people in prison the confidence and understanding to pass their knowledge on to others. The programme started with an interactive workshop for 12 people, with information and facts about risk, transmission and exposure to HIV, HBV and HCV. The aim was for this knowledge to be cascaded to other prisoners. The cascade approach was immediately successful, shown by the fact that 30 people asked to attend the second session. Key messages about risk, how to stay safe and also about

the importance of HBV vaccinations were taken on board.

This programme provides valuable skills to those involved as well as raising awareness and knowledge within the prison community.

## 7.5 BBV awareness training in prisons in Northern Ireland

A bespoke BBV awareness session took place on three separate days at HMP Magilligan. Red Cross Facilitators carried out the training for people in prison and prison staff. The sessions were designed to raise awareness, identify and manage BBV risk and to educate and support people. As well as the benefit to those attending, the impact was extended to the wider prison community as attendees were supported to use leaflets that were provided to talk with others about BBVs.

Feedback from participants was very positive and, since the BBV awareness sessions, requests for BBV testing have increased as have requests for the HBV vaccine.

The success of this programme led to an expansion to other sites. 15 awareness sessions across three prisons in Northern Ireland have provided the opportunity to speak to 129 people in prison and 120 staff members. There are now plans to develop an accredited BBV programme.

<sup>16</sup> For more detailed information please see Professional standards for optimising medicines for people in secure environments, Royal Pharmaceutical Society, (2017).

# Appendix Blood-borne viruses: The basics

## 1. Hepatitis B

Hepatitis B virus (or HBV) is a virus which infects the liver, and can stop the liver from working properly. This can lead to liver cancer, and can be fatal in some cases. Most people will recover from HBV without treatment within six months of infection, unless they were infected at birth or in childhood. Even for those who do not recover treatment is not always necessary. Treatment rarely cures the infection but it can keep it under control and prevent liver damage. The most common treatment for those who need it are anti-viral pills that have to be taken daily for years. They have very few side-effects. Sometimes Interferon is used instead in a 48-week course. This can have more side-effects.

### Transmission

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

- Sharing injecting drug equipment, including spoons and filters
- Sharing equipment for snorting drugs such as straws or rolled notes
- Sharing tattooing or piercing equipment
- Sex without a condom.

People in prison are identified as being at particular risk of HBV because of the high proportion who have been (and/or are) injecting drug users.

### Vaccination

A vaccine is available and is 95% effective at preventing children and adults from developing HBV if

they have not yet been infected. In prison settings it is recommended that the super-accelerated vaccination schedule be offered to all (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 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 risk and there should be no delay in vaccination. The HBV vaccine is very safe and there are no contraindications from receiving extra doses.

### Post-exposure prophylaxis

If someone has been exposed to HBV, there is treatment available which can stop them from becoming infected. They should immediately be given an injection of antibodies called immunoglobulin. Ideally, the injection should be given within 48 hours (although it can be considered up to a week later) after potential exposure to HBV to have a chance of stopping infection. It should be given whether or not the person has been immunised against HBV, since complete immunity cannot be guaranteed. If someone has not been immunised, they should also be given the vaccine at the same time.

## 2. Hepatitis C

Hepatitis C virus (HCV) can also severely damage the liver, as well as other parts of the body including the immune system and brain.

New HCV medication has been developed in the last few years and is now being used by the NHS. This new form of medication, called direct-acting antivirals (DAAs), is incredibly effective and has been shown to rid patients of the virus in over 90% of cases. DAAs

are taken in tablet form usually on a daily basis. Treatment for HCV lasts for 12 to 24 weeks and is less demanding and more tolerable (fewer side effects) than older HCV treatments. DAAs have replaced combination therapy of two drugs, Interferon and Ribavirin, as the first line treatment for HCV.

In England, the number of patients that can be treated using DAAs was capped at 10,000 patients in 2016/17 and 12,000 patients in 2017/18. These caps mean that in a few areas there might be waiting lists for HCV treatment.

### Transmission

The route of transmission for HCV is blood. Transmission routes in prisons are:

- Sharing injecting drug equipment
- Sharing equipment for snorting drugs such as straws or rolled notes
- Sharing tattooing or piercing equipment
- Sex without a condom, where blood or trauma are involved.

Again, prisoners are identified as being at particular risk of HCV because of the high proportion of prisoners who have been (and/or are) injecting drug users.

### Vaccine

There is currently no vaccine to prevent HCV.

### Post-exposure prophylaxis

There is currently no treatment which can be given to prevent someone from being infected after they have been exposed to HCV. However, treatment is available for HCV. Treatment given is effective in clearing the virus in over 90% of people, particularly if given before the patient has developed severe liver damage.

## 3. HIV

HIV (Human Immunodeficiency Virus) is a virus which attacks the immune system—the body's defence against diseases. Without medication people with HIV will develop AIDS (Acquired Immune Deficiency

Syndrome). AIDS is the most advanced stage of HIV infection, when the immune system can no longer fight infections. Someone with AIDS has both HIV and at least one of a specific list of 'AIDS-defining' diseases, which include tuberculosis, pneumonia and some types of cancer.

HIV treatment, called antiretroviral therapy (ART), keeps the virus under control and the immune system healthy. Treatment is now so effective that it reduces the amount of virus in the body to such low levels that it cannot be passed on. This means someone doing well on treatment is no longer infectious. There is no cure for HIV but if diagnosed on time and on treatment, a person living with HIV can expect to have a normal life expectancy.

It is important that treatment is taken at the right time and in the way prescribed by the doctor. If a break in treatment occurs, HIV can develop resistance to the drugs and the treatment may fail.

### Transmission

HIV can be transmitted through bodily fluids such as semen, vaginal fluids, blood, and breast milk. Key transmission routes in prisons are:

- Sex without a condom
- Sharing needles, syringes and other injecting drug equipment
- Tattooing equipment.

Prisoners are at particular risk of HIV because of the high proportion of prisoners who have or continue to inject drugs.

### Testing

HIV can be diagnosed through a blood or saliva test from four weeks after infection occurs. If the result is negative then a further test should be taken three months after the person was exposed to the virus to confirm this negative result. Opt-out HIV testing for all people in prison is now recognised as good practice and an important part of healthcare policy in England, Scotland and Wales (See Box 2: Opt-out BBV testing for further information).

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### Vaccine

There is currently no vaccine to prevent HIV. PrEP (Pre-exposure prophylaxis) is a regimen of an HIV treatment drug that will prevent a person from acquiring HIV. At point of publication NHS England is developing a trial that will make this available to those at higher risk of HIV in England.<sup>17</sup> The drug is already available in Scotland and Wales.

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<sup>17</sup> For more information on the PrEP IMPACT Trial, go to <https://www.prepimpacttrial.org.uk/>



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# SHAPING ATTITUDES CHALLENGING INJUSTICE CHANGING LIVES

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