



Medication in-possession

A guide to improving practice in secure environments

August 2005

The Scottish Prison Service has been developing and supporting a range of self care models throughout the Service for some considerable time now. The purpose of which is to effectively move towards prisoner patients being responsible for their own care. Our Drug and Therapeutics Committee introduced a policy for the supply of medicines in 2001. The policy covers a range of issues including assessment, medicines that may or may not be given in-possession and patient contracts. In practice the in-possession element of this has largely been successful with relatively few difficulties experienced in our establishments.

John Porter
Nursing Services Manager, Scottish Prison Service HQ

The project team

Annie Coppel, Director of Publications and Corporate Governance, National Prescribing Centre (NPC). Annie provided pharmaceutical and prescribing advice in primary care for a number of years before joining the National Prescribing Centre, where she is currently responsible for the strategic development and management of two main elements of the NPC work programme — the national MeReC Publications portfolio and New Medicines Scheme, as well as the corporate governance of the organisation. Over the years, she has developed and delivered specific projects supporting national policy initiatives in prescribing and medicines management. This includes the publication of several NPC resources promoting and sharing good practice.

Sue Faulding, Senior Pharmaceutical Adviser, Prescribing Support Unit, Health and Social Care Information Centre. Sue has many years of experience in hospital pharmacy and primary care, including a secondment to the prescribing branch of the Department of Health. Currently, she is the clinical member of an analytical and policy team at the Prescribing Support Unit, and also a Training Adviser for the NPC therapeutic programme.

Administrative support

Annette Ireland has worked for the NPC since it was created in April 1996. She is currently Programme / Support Manager at the NPC and has provided administrative support to this project and designed the layout of this document.

For further information contact Annie Coppel, Director of Publications and Corporate Governance, NPC
Tel: 0151 794 8210 Email: annie.coppel@npc.nhs.uk

Foreword

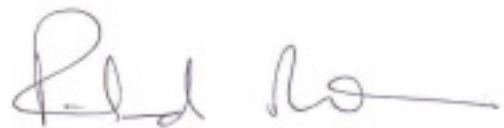
In June 2003, *A Pharmacy Service for Prisoners* (published under PSI 028/2003), set the policy for the increasing use of medications in-possession in the prison service.

To support all prisons in England and Wales, and their Primary Care Trusts / Local Health Boards (PCTs), develop and implement a local policy for medication in-possession, Prison Health commissioned the National Prescribing Centre to produce this *guide to improving practice*.

The guide has been developed with input from a wide range of prison and PCT staff, drawing on those with experience of medication in-possession, and seeking the views of others. Its content, which is not mandatory but reflects good practice, aims to:

- Support local prison / PCT partnerships to move, in a managed way, to the default position where patients in prisons normally manage their prescribed medication
- Share and disseminate known good practice and expertise more widely
- Prevent duplication of effort, and offer a consistent approach to this developmental work across the prison estate
- Recognise that each prison will be starting from a different position in the extent to which it has medication in-possession, and may follow a different process, appropriate to local circumstances, for its safe introduction and / or development

I commend this guide to staff within both prisons and PCTs, and I am sure that prison and PCT staff will wish to consider this report and its action plan on page 19 in their Partnership Board meetings.



Richard Bradshaw
Director Prison Health
Department of Health

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Terminology used

The following terms are used throughout the document:

- Medication includes medicines and associated devices
- Patient — a patient in a prison
- Drug and Therapeutics Committee — or equivalent committee established to deal with medicines and prescribing-related issues for the prison (D&TC)
- Primary Care Trusts in England or their equivalent Local Health Board in Wales (PCTs)

Executive summary

Background

The government is committed to providing a health service to prisoners that is equivalent in quality and range to that in the wider community. *A Pharmacy Service for Prisoners* (HM Prison Service / DH 2003) defined how future pharmacy services should be provided to patients in prisons. It set the way forward, through a number of recommendations, for the development of more patient-focused, primary care-based pharmacy services based on identified need, which support and promote self-care. Issued as Prison Service Instruction 028/2003, *A Pharmacy Service for Prisoners* requires prisons to put systems in place for the modernisation of pharmacy services — and progress is being monitored. Pharmacy leads have been appointed at regional level to support and guide prisons and Primary Care Trusts (PCTs) in the development of local action plans.

Policy recommendation

Recommendation 5 of *A Pharmacy Service for Prisoners* set the policy for the increasing use of medications in-possession.

Medicines in use, together with associated monitoring and administration devices, should normally, as a matter of principle, be held in the possession of prisoners.

Each prison should have a policy and risk assessment criteria, developed through the Drug and Therapeutics Committee (D&TC), for determining on an individual basis when medicines and related devices may not be held in the possession of a prisoner.

The basic principle is that, in line with the general public, patients in prisons should be treated as responsible people. Medication in-possession supports the NHS principle of empowering patients to take an active role in managing their own care. Engaging and involving patients in their treatment facilitates more effective medicine taking, and can help them gain the most from their medicines both whilst in prison and when discharged.

Many establishments have already implemented this recommendation, and many more are moving to this position. Hence different prisons are at different stages in the process. It is expected that D&TCs develop policies to reflect local issues related to their prison category and population status, and fully implement the recommendation in an incremental manner.

In Spring 2004, the NPC conducted a questionnaire-based survey of the 138 prisons in England and Wales. A total of 54% of prisons responded, of which 77% had an approved policy for medication in-possession, which they were actively implementing. A further 19% were in the process of developing a policy.

NPC survey of prisons in England and Wales. Spring 2004 (data on file)

The Support

The NPC was commissioned to produce *Medication in-possession: a guide to improving practice in secure environments* to support all prisons in England and Wales, and their PCTs / Local Health Boards, to develop and implement a local policy for medication in-possession. Developed with input from a wide range of prison and PCT staff, drawing on those with experience of medication in-possession, and seeking the views of others, the guide aims to:

- Support local prison / PCT partnerships to move, in a managed way, to the default position where patients in prisons normally hold and use their own medication
- Share and disseminate known good practice and expertise more widely
- Prevent duplication of effort, and to offer a consistent approach to this work across the prison estate, recognising that each prison will be starting from a different baseline and may follow a different process, appropriate to local circumstances

The guide, which contains no mandatory instructions, explores the principles behind the recommendation for medication in-possession, and the potential benefits it may bring to patients, prisons and their staff. It offers an informed range of practical issues to consider for the successful development and implementation of a local policy, as well as exploring the potential content of such a policy. Based on current prison experience, it also presents a series of points to consider when developing the local risk assessment process and criteria for determining when medication in-possession is not appropriate for an individual. Further supporting sources of information are also signposted.

To help share learning and experience, and to prevent duplication of effort, examples of local prison practice have been posted on www.npc.co.uk, www.npc.nhs.uk and on the **prison service intranet**, and are available for download. These include medication in-possession policies, risk assessment tools and criteria, and patient-prison agreements. Prisons are being encouraged to share further examples on these websites, as experience is gained across the prison estate, to continue to spread best practice.

Primary audience

This guide is aimed at any person who is responsible for, and involved in, the implementation and management of medication in-possession in prison establishments.

A paper copy has been mailed to:

- Governors, healthcare managers and pharmacists in prisons
- Chief executives, lead prescribing advisers and prison pharmacy leads in PCTs
- Regional prison, pharmacy, medical and nursing leads
- A range of other professional bodies and related organisations

The guide is available electronically, under the publication section, on NPC websites at www.npc.co.uk and www.npc.nhs.uk, and also from www.hsmc.bham.ac.uk/prisonhealth/ and the **prison service intranet**.

Introduction

Health and pharmacy services for prisoners

In 1999, the Government committed to providing a health service to prisoners that is equivalent to that in the wider community.¹ Formal partnerships between HM Prison Service and the National Health Service (NHS) were developed to enable this.

To support the commitment, budgetary responsibility for all prison health services transferred from the Home Office to the Department of Health (DH) in April 2003, and the devolution of commissioning responsibility to those PCTs which host prisons, will be completed by April 2006.

In June 2003, HM Prison Service and the DH jointly published a report called *A Pharmacy Service for Prisoners*.² It was produced as part of a wider programme to bring improvements in health care delivery to prisoners, and in particular to address the wide variation in, and quality of, the provision of pharmacy services across the prison estate. Thirty recommendations set out a way forward for the development of more patient focused, primary care based pharmacy services to prisoners based on identified need, and which support and promote self-care.

This report, and its recommendations, were endorsed by the Prison Service Management Board and issued as Prison Service Instruction 28/2003 in England*.³ This requires all Governing Governors, Directors and Controllers of contract-out prisons in England to ensure that systems to support the modernisation of pharmacy services are in place.

Progress made against this will be monitored initially through Standard 22 of the Prison Service Performance Standards (Health Services for Prisoners).⁴ As commissioning responsibility transfers to the NHS, so too will the responsibility for quality assurance. Arrangements for April 2006 onwards are currently being finalised.

Medication in-possession: what is expected?

A Pharmacy Service for Prisoners defines how pharmacy services should be provided to patients in prisons in the future, to ensure they deliver standards of care equivalent to the NHS.

Recommendation 5 specifically relates to the use of medication in-possession, and states²:

Medicines in use, together with associated monitoring and administration devices, should normally, as a matter of principle, be held in the possession of prisoners.

Each prison should have a policy and risk assessment criteria, developed through the Drug and Therapeutics Committee (D&TC), for determining on an individual basis when medicines and related devices may not be held in the possession of a prisoner.

The aim is to move towards patients being responsible for holding and using their own medicines.

* Although *A Pharmacy Service for Prisoners* has not been formally adopted in Wales the principles have been accepted.

It is not intended that establishments adopt this position for *all* medications and *all* patients. However, this should be the normal position unless there are clearly identifiable factors why this should not be the case for an individual. Special consideration will be required for juveniles and women (see page 8).

From a survey conducted by the NPC in Spring 2004, it is known that many establishments in England and Wales have already implemented this recommendation, and many more are moving to this position. Hence, different prisons are at different stages in the process. It is expected that they will develop policies that reflect local issues related to prison category and population status, and will fully implement this recommendation in an incremental manner.

A Pharmacy Service for Prisoners clearly states that the policy and the risk assessment criteria should be developed by the local prison D&TC. There should be a process for assessing the risk on an individual basis.

The policy developed for medication in-possession should take into account, and link with, other relevant prison health care, drug strategy and security policies. For example, medicines management, clinical governance, security policies, supply reduction and drug testing programmes, harm reduction, etc.

The Prison Health Partnership Board is responsible for the modernisation of health services for prisoners. Governors have continuing responsibility for facilitating the delivery of health care within the custodial environment, and will need to ensure their senior management team is fully engaged in implementing their local medication in-possession policy.

What does this resource aim to do?

Commissioned from the NPC by Prison Health, this guide has been produced to support all prisons in England and Wales, and their PCTs, to develop and implement a policy for medication in-possession.

It aims to:

- Help local partnerships assess their current position, and support them to move, in a managed way, to the default position where patients in prisons normally hold and use their own medications
- Share and disseminate known and good practice and expertise more widely. It has been developed with input from a wide range of prison and PCT staff, drawing on those with experience of medication in-possession, and seeking the views of others
- Help avoid duplication of effort, and offer a consistent approach to this work across the prison estate — recognising that each prison may follow a different process, as appropriate to local circumstances, to develop and implement their policy

While it has been written in a generic manner to cover establishments of all security status and type, it does acknowledge that there may be additional considerations for some prisons. For example:

Local prisons have very high levels of transfer such that patients may be less settled and less well known to staff. Therefore, medication in-possession may need to be introduced with extra prudence. Whilst a greater proportion of patients may be identified as less suitable for taking responsibility for their own medications than those in other types of establishment, there may well be more stable wings in a local prison that still allows a staged implementation.

Juvenile establishments will have issues of consent to consider. Young people of 16 years and over are competent to consent to treatment even though they are under the legal age of majority (18 years). The courts have stated that those *under 16 will* be competent to give valid consent to a particular intervention if they have 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.⁵⁻⁶

Women's prisons tend to have a high proportion of prisoners with mental health problems and a history of self-harm. Women place a greater demand on medical services than men, with high demand for drug and mental health services. A significant number of female prisoners are mothers, and many have a child with them in prison.⁷ These and other factors will need to be considered when developing policies and criteria for medication in-possession in women's prisons.

What support does it offer?

This guide will help prisons and PCTs:

- Understand the rationale for, and potential benefits of, medication in-possession
- Provide a framework to support prison D&TCs to develop a policy for medication in-possession, and the risk assessment criteria to determine when medication in-possession is not appropriate for an individual
- Identify the best local approach to develop and implement a policy — for those prisons where this does not yet occur
- To be reassured about what they have already achieved, and to support further developments as they move towards having in-possession as the normal situation — for those prisons who have already started implementing an in-possession policy
- Be aware of the available, although limited, evidence base
- Access examples of good practice
- Access examples of policies and risk assessment tools already in use
- Access further sources of useful supporting information

Who should read this guide?

This guide is primarily aimed at anyone who is responsible for, and involved in the implementation and management of, medication in-possession in prisons.

These may include:

- Prison governors
- Prison D&TC
- Prison pharmacy provider staff
- Prison health care staff
- Prison discipline staff
- Regional prison health pharmacy leads

- PCT chief executives
- PCT prescribing leads
- PCT clinical governance leads
- Strategic Health Authority (SHA) prison health leads
- SHA prescribing leads

Other people who should be aware of this guide include:

- PCT Professional Executive Committee Board members with responsibility for prison health care services
- PCT directors with responsibility for prison health
- PCT staff involved in providing advice and support to prisons on prescribing, pharmacy and medicines management issues
- Chair of area prescribing committee
- PCT commissioning lead
- Mental Health Trust staff providing in-reach services

Links to examples of good practice

A number of establishments have kindly shared examples of their local medication in-possession policies and risk assessment tools, to help spread experience and learning. These are available at:

- www.npc.co.uk (Internet)
- www.npc.nhs.uk (NHSNet)
- **Prison service intranet**

It is intended that further examples of good local practice will be shared on these sites as experience is gained across the prison estate.

Health care in prisons

The prison population

The aim of the prison service is to effectively execute the sentences of the courts in order to protect the public and to reduce re-offending.⁸ At any one time, the prison population is around 74,000.⁹ Approximately 150,000 prisoners pass through the prison system each year,¹⁰ and about 2,000 move between establishments each week.²

The majority of this population is male (~95%), predominantly young, and serving relatively short sentences. Many re-offend and are regularly in prison.¹¹ Nearly half of the female prisoners have been abused, and over 40% have self-harmed or attempted suicide.⁷ Around 55% of prisoners report a severe drug problem.¹²

Improving health care in prisons

The government is committed to an ongoing programme of work to improve the organisation and delivery of health services for prisoners to:

- Ensure that prisoners have access to the same quality and range of health services as the general public receives from the NHS
- Facilitate efficient and effective use of prison and NHS resources when delivering health care to prisoners¹³

Generally, prisoners tend to have much poorer physical and mental health than the wider population. Mental illness, drug dependency and communicable diseases are the prevailing health problems.² As in the community, prisoners with long-term conditions require ongoing support, monitoring and treatment. The health care services provided in prisons are essentially primary care services and, in line with the NHS, should aim to support and promote self-care. Even though 80% of those in prison are there only for six months or less, high quality and effective health care can contribute significantly to their overall health, as well as improving their capacity to benefit from education, drug treatment and other programmes.¹⁰

- 90% of all prisoners have a diagnosable mental health problem and/or substance misuse problem
- 80% smoke
- 24% report having injected drugs
- 13% have diagnosed asthma
- 8% of a representative sample were positive for Hepatitis B, 7% for Hepatitis C, and 0.3% males and 1.2% females for HIV²

Pharmacy services in prisons

Pharmacy services are delivered to prisoners by pharmacists and support staff employed by the prison service and by private contractors, and by NHS providers such as hospital pharmacy departments in NHS Trusts and community pharmacies. However, the services, and the staff that provide them, can be isolated resulting in fragmentation and variation, and making staff-patient contact extremely difficult.

The prison service spends approximately £7million per annum on medicines, and expenditure per patient varies widely.² Studies of health care in women's prisons report high levels of prescribed medication compared with male prisoners and with women in the community.⁷ Medicine-taking has an influence on the prison regime as a whole.²

Nearly all establishments run treatment times, when patients in prisons are required, or are able, to attend to collect their medicines. This may be for prescribed medication and / or to request treatment for minor ailments. In some prisons, medicines are routinely handed out on a dose-by-dose basis by non-pharmacy staff without perhaps consideration of alternative systems or the safer prescribing that medicines management can bring. This can be extremely time consuming and inefficient, disrupting the prison and utilising huge health resources.¹⁴

The vision for future pharmacy services is that they will:

- Offer an equivalent range and quality of primary care services as those in the NHS
- Support self-care and patient self-management
- Improve medicines management in prisons
- Improve health gain from appropriate use of medicines for patients
- Enable increased contact between patients and pharmacy staff
- Make better use of the skills and expertise of prison pharmacy staff, and ensure they have access to appropriate training and continuing professional development
- Provide a more efficient system for the supply of medicines
- Support other health care staff and the establishment as a whole

Joint work between prison and PCT staff to implement these recommendations will be required to move this agenda forward in this direction.

Self-assessment against performance standard 22 (*Health Services for Prisoners* — May 2004), which defines the required outcome and key audit baselines for prison pharmacy services, will ensure that the Standard is applied and met until April 2006. External audit by the Standards Audit Unit will give essential external assurance on critical baselines.⁴ Once the transfer of commissioning of health care services to the NHS is complete in 2006, the Standard in its current format will be replaced by a health services standard that is more relevant to the prison service. Future inspection arrangements are currently being explored.

Medication in-possession

Many prisons, of all types, have an adopted policy for in-possession. These define under which conditions which medicines, and in what quantities, can be supplied. However, this approach means that 'not in-possession' is the default position in practice. It also means that risk management issues are bypassed to what is perceived as the lowest level of risk.

For effective and efficient patient care, *A Pharmacy Service for Prisoners* (Recommendation 5) changes this default position from a negative to a positive one — where risk levels are to be correctly identified, assessed and managed, so that in practice medications are normally held 'in-possession', i.e. prisoners are screened 'out' rather than 'in'.

In Spring 2004, the NPC conducted a questionnaire-based survey of the 138 prisons in England and Wales. A total of 54% of prisons responded, of which 77% had an approved policy for medication in-possession, which they were actively implementing. A further 19% were in the process of developing a policy.

NPC survey of prisons in England and Wales. Spring 2004 (data on file)

The case for medication in-possession

The basic premise is that, in line with the general public, patients in prisons should be treated as responsible people. A large number of them are perfectly capable of taking responsibility for storing and using their medication, and in fact have been used to doing so when in the community. Many of those with a long-term condition have an excellent understanding of their chronic disease and its management — and a majority of those without ongoing health problems will have a good knowledge of self-treatment for minor ailments, and the sources of help and treatment available in the community.

Continuing self-care is important as the majority of prisoners serve relatively short sentences, and there is regular movement within and between establishments, and between courts and establishments. Medication in-possession can provide continuity of care in medicine taking, and reduce waste and improve efficiency, e.g. prisoners in transit with access to their medication can take them at the appropriate time.

There are many potential benefits of patients in prisons having medications in-possession, including improvements in the quality and continuity of care provided, and in the workload and skill utilisation of pharmacy and other health care and prison staff. These are discussed more fully overleaf.

Understandably, as medicines can be used for suicide, self-harm and abuse, there is concern that increasing the amount in prison circulation might mean there would be increased opportunity for, and resulting higher levels of, harm.

It is good practice, when introducing any change to a service or system, to monitor all resulting effects — some of which will be planned, and some of which will not. **Local audit and reporting on self-harm incidents and other adverse events in relation to prescribed medicines, both before and after changes to local policies and systems are made, will be an important part of the implementation of an in-possession policy.**

In 2003, 4.6% of all reported self-harm incidents in Her Majesty's Prison Service (HMPS) (n=16,221) were due to poisoning with own medication / other person's medication.¹⁵

In 2004, there were 95 reported self-inflicted deaths in HMPS. Two of these were attributed to overdoses of prescribed medication.¹⁶

Potential benefits of medication in-possession

This section outlines some of the benefits that are potentially realisable from the implementation of a medication in-possession policy and the related changes in pharmacy service provision.

For patients in prisons:

- Able to take an active role in managing their own care in prison, and on discharge
- Able to use medicines and associated devices at the appropriate time
- Improved contact, and partnership, with health care professionals on medicine taking
- Increased access to education and counselling about their condition and medications
- Improved concordance with advice and medications
- Better management of long-term conditions
- Improved health
- Reduced time spent in queues at treatment times
- Reduced likelihood of missing doses on transfers, court visits or on release

Establishing a chronic disease management clinic for the monthly assessment of relevant patients, alongside giving monthly supplies of medication in-possession has reduced the daily and weekly workload for both health care and pharmacy staff in a category C establishment. The care delivered to patients has also been improved and enhanced.²

The NHS Plan^{*}, published in July 2000,¹⁷ outlined the vision of a health service designed around the patient. A key theme is empowering patients to take an active role in managing their own care. Medication in-possession supports this principle. Patients in prisons can maintain responsibility for self-administration, and at the appropriate time, when transferred around the prison estate and on release, ensuring continuity of care. Those preparing for release can be supported to adjust to this responsibility.

For some patients, particularly the old and frail, the time spent queuing for a medication supply at treatment times, possibly several times a day, can be an ordeal. The existing queuing system may increase vulnerability and stress, as other prisoners can see what medications are being supplied. In-possession may provide greater confidentiality for these patients, and may reduce the risk of bullying when queuing for medications, as reported anecdotally in some prisons.

Prison staff report that patients in prisons do not attend, or are late for, activities due to the time spent waiting at treatment times. Persistent non-attendance or lateness for activities may lead to loss of privileges in some circumstances.

There may be increased opportunity for direct contact with pharmacy and other health care staff as altered time commitments in the dispensing and administration of medicines may allow these staff to utilise their time more gainfully on other aspects of patient care. For example, to provide education and counselling thus improving the patient-staff relationship, improving patient health awareness and, knowledge and understanding of long-term conditions and their management, and the medications used to treat them.

* In Wales see: *Improving Health in Wales: a plan for the NHS and its partners* January 2001 www.wales.gov.uk

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Engaging and involving patients in their treatment facilitates more effective medicine taking,¹⁸ and medication in-possession can help prisoners take their medicines appropriately, and gain the most from them both whilst in prison and when discharged.

The elderly is a rapidly increasing population group in prisons as the number of prisoners over 60 years of age has trebled in a decade.¹⁹ This group in particular may benefit from regular health assessments in line with a number of National Service Frameworks (NSFs),²⁰ such as the NSF for Coronary Heart Diseases. Such prisoners are likely to require more medicines to manage long-term conditions.

List here any other specific patient benefits that you anticipate, or that your prison has found, from the introduction of a medication in-possession policy

For prison staff:

Health care staff

- More productive use of time and of clinical and professional skills to improve patient care as:
 - Less time spent dispensing daily doses, and handing out medications at treatment times
 - Lower demand on staff resources through reduced numbers of treatment times
 - More efficient systems of supplying regular medications
- Opportunity to engage with multi-disciplinary care of patients
- Role enhancement, e.g. supplementary prescribing, medication review, supply through Patient Group Directions, etc.
- Safer medication handling processes, e.g. dispensing, administration, etc.
- Improved medicines management
- Increased patient contact time
- Increased job satisfaction

A key aim of the NHS Plan¹⁷ is to make better use of the skills of staff. Medication in-possession is likely to change the time commitments of, and resource demands on, pharmacy and other health care staff in the dispensing and administration of medicines. While it is recognised that a proportion of time will be utilised in the risk assessment of individuals, opportunities may arise to make better use of professional and clinical skills to develop and deliver other health care services. These might include participation in multidisciplinary clinics (smoking cessation, diabetes, etc.), medication review, health promotion, etc. increasing contact time with patients and other staff. It also may offer the prospect of developing new skills and taking on new roles, such as supplementary prescribing, managing minor ailments, etc.

Increased contact time with other prison staff may also bring benefits such as improved education and training, and more support in medicines management and related processes.

List here any other specific benefits for staff that you anticipate, or that your prison has found, from the introduction of a medication in-possession policy

For the prison service:

- More appropriate and productive use of staff skills and competencies
- Improvements in staff satisfaction, which may have implications for staff retention
- Improved health gain from more appropriate use of medicines
- Improved medicines-related culture
- Improved prisoner attendance at activities
- Smoother process around movements and transfers
- Positive financial impact on drug spend
- Improved commitment to, and development of, other medicines management policies

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Managing medication in-possession may alter the time commitments required by certain staff groups to perform certain duties. Changes in the time spent giving out medications could be redeployed within health care, enabling staff to use their skills and competencies more appropriately to improve service delivery. Over time, this may contribute positively to staff job satisfaction and retention.

The use of medicines is the most common therapeutic intervention carried out in the NHS.²¹ It is important that medicines are provided in a way that is clinically effective, and regular reviews are needed. Medicines with a single daily dose administration and modified release formulations are regularly used in prisons in an attempt to manage the dispensing workload and the number of daily treatment times required. Generally these formulations are more expensive, which is a consideration for prison drug expenditure.

Similarly, there is the potential to reduce waste and to smooth prisoner transfer processes. Movement around the prison estate can result in a patient missing doses, and medication being lost or mislaid on transfer or discharge. Also, waiting for a supply to be dispensed to an escort or for discharge can be a rate-limiting step in the process of transfers. Preparation for transfer to court or other establishments may be simplified by medication in-possession, as properly labelled containers, rather than a single day supply in an envelope, will reassure transfer and escort staff about appropriate medication. This also provides better compliance with the Medicines Act.

Most prison establishments provide up to four treatment times per day, although some provide up to six.² If medicine administration times are shorter and / or less frequent, it will be easier to accommodate them within the prison regime.

A possible, and very valuable, gain might be an improvement in the medicines-related culture within the prison — if it is emphasised that medications to be held in-possession are not intrinsically going to be of abuse value. Prisoners working as 'listeners' report that all medicines are regarded as having potential trading value. This is because some prisoners believe that all medicines are 'drugs' in the lay sense, and will give them a 'buzz' or status in the local hierarchy. Better understanding of the role and use of medicines for long-term conditions might prevent or reduce the extent to which they are stolen, traded or hoarded.

List here any other specific benefits for the prison that you anticipate, or that your prison has found, from the introduction of a medication in-possession policy

Policy development and implementation

All prisons, in conjunction with their local PCT, should be covered by a D&TC or equivalent. This committee draws on specialist expertise and is responsible for the development of medicines and prescribing related policies and procedures. It is the responsibility of this committee to develop a policy and risk assessment criteria for determining, on an individual basis, when medicines and related devices may not be held in the possession of a prisoner.²

There are a number of factors that contribute to the successful development and implementation of any service change, including effective leadership, buy-in and commitment from all relevant stakeholders, tight planning and project management, good communication, and persistence balanced with flexibility. (Resources to understand the issues that aid or hinder change, and the tools and methodologies available to help manage change, are found in Appendix 1).

However, in everyday situations, most people are concerned about the issues outlined below. Asking these initial questions may help with orientation around the need for change, and to start planning and implementing the policy.²²

Who wants the change? And why?

- Where is the drive for the change coming from?
- How powerful is it?
- Is it from within the service or organisation? Or is the change being imposed?
- Who is opposed to the change? And why?

Importance for the unit / organisation

- How does the change fit in with other performance objectives? What priority should be given to this initiative?
- How radical is the change needed?
- Are we already doing something to address the issues involved in the initiative?

Performance measurement

- Who is measuring the success of the change?
- What are their concerns and how do they measure success?

Consultation with staff

- What groups are involved in, or affected by, the change?
- How easy will it be to involve these groups in discussions and in the development of the solution?
- Are the staff groups concerned already involved with a number of other changes?

It is recognised that every establishment will have a different starting point. Also, that different people involved in the change will have different views of the proposed change, of the underlying causes of the problem, and of the desired outcome. Therefore, each prison should move forward at a pace that suits their local circumstances.

In practical terms, the following key steps are likely to be taken:²³

- Develop the strategy
- Develop and agree an action plan
- Develop the policy
- Pilot the policy
- Roll out the policy
- Evaluate the impact
- Build on the policy

Issues to consider

The information contained on the following four pages is a comprehensive, although not exhaustive, range of issues that prisons and PCTs may wish to consider during the development and implementation of a local policy. They draw on the practical experience and knowledge of those consulted during the production of this guide.

Strategy and action plan

Ensure that a local prison D&TC or equivalent committee is in place, and has the appropriate membership and authority to effectively carry out the responsibilities required. Also consider links to other relevant groups, e.g. prison security department

Ensure the commitment and support of the Governor, prison and partnership board as staff implementing a new policy need to feel supported

The responsibility for developing the policy and risk assessment criteria rests with the D&TC. Consider where the responsibility lies for implementation, and who will lead and manage the project. It is important that if a working group is set up to drive forward the process, it has support from the D&TC and Governor, e.g. in order to have credibility

Imposed changes tend to be resisted. It is crucial to identify and involve all key stakeholders right at the very beginning (See Table 1 overleaf). **Innovations fail on this point alone.** Consider:

- Which staff may be directly involved? E.g. health care, discipline, security and wing staff (regular and agency / locum)
- Which staff groups may subsequently be affected by the change in practice? E.g. regime and escort staff, substance misuse and CARAT teams, mental health in-reach teams, visiting specialists, security and drug strategy coordinator
- Who will the service impact on? Involve patients and prisoners — use representatives of patient and prisoner groups who are most likely to receive the service as it is important to understand how they perceive and experience the service
- Who else? E.g. PCT staff and clinical governance representatives

Determine accurately the prison's current position on medication in-possession, and conduct a baseline audit with respect to adverse events. This data will help provide a sound baseline for planning, monitoring progress, auditing outcomes, and sharing learning

Conduct a risk assessment as part of the introduction / enhancement of an in-possession initiative and resulting service re-design

Develop an action plan with clear and specific objectives, and appropriate, agreed timescales, which reflect local circumstances. Define what can be achieved by the potential service changes, what risks are associated with the changes and how they are to be managed

Determine the implementation approach — this will be decided by taking account of the current position. Full implementation is likely to involve a long-term commitment, and it may be more appropriate to plan for an incremental implementation

Make life easier by linking up with other similar or nearby establishments to share experience, ideas and learning — it can save time and effort

Table 1 — Who was / should be involved in drawing up the policy for in-possession?

- Drug and Therapeutic Committees
- Pharmacist from pharmacy service provider
- Pharmacy technician from pharmacy service provider
- General practitioner
- Senior medical officer
- Head of health care / health care manager
- Senior nursing representative
- Non-medical prescribers
- Security manager
- Prison officer / Prison Officer Association representative
- Governing governor
- Special search team representative
- Independent Monitoring Board representative
- Wing manager
- PAT audit team adviser
- Mental health team leader
- Suicide prevention team
- Service users, e.g. prisoner group
- PCT clinical governance lead
- PCT pharmaceutical / prescribing adviser
- PCT primary care development manager

**NPC survey of prisons in England and Wales.
Spring 2004 (data on file)**

Policy development

Ensure the policy is not developed in isolation from other relevant key medicines and security related policies and priorities

Form close links with the PCT clinical governance team to ensure that clinical governance issues are considered. Clinical governance is an essential element that underpins any service in the NHS. It is important to be able to demonstrate the quality of a service, manage risks within the service, and to continually monitor the service to maintain or improve standards.²⁴ For example, there should be robust protocols in place to manage every aspect of the policy, and it should indicate how overall management of this policy links into clinical governance structures

Many prisons have found it possible to move to a position where, with careful prescribing and audit systems in place, most medications can be given in possession. However, there may be some local situations, e.g. particular locations such as remand wings, and some medications (such as controlled drugs) and particular patients, where medication in-possession may need to remain limited, if used at all

The policy, and any associated risk assessment tools are dynamic, and should be reviewed and modified over time in response to changing circumstances and experience

Implementation

Run a pilot

- Pilots allow early problems to be identified and sorted out, and help to demonstrate perceived benefits
- Consider starting in a segment of the prison where there are good inter-professional staff relationships, a known and stable prison population, and a willingness to try something new. It is easier to implement a change where there is some enthusiasm for it, or the least resistance to it
- Consider also starting with certain safer groups of medications, and then gradually extending through the local formulary
- Pilots can help to reassure and build confidence in those providing and receiving the service
- It is better to start small and then build incrementally once the pilot is running smoothly

Making improvements in services requires change, which can appear threatening or overwhelming for busy people doing demanding work. The NHS Modernisation Agency recommends use of a collaborative methodology called 'Plan, Do, Study, Act' (PDSA), which has been used within the National Medicines Management Services Collaborative. The PDSA cycle is a way to break down the process of change into manageable chunks, and test each small part to make sure things really are improving and that effort is not wasted.²⁵

Rolling out more widely across the establishment may involve introducing in-possession to other wings, or to additional patient groups, or to cover additional medicines for long-term conditions. It should be done in a manner appropriate for the setting, and with local agreement

Ensure all stakeholders understand why the change is taking place, and the potential benefits for each staff group and for patients. It is equally important to identify potential risks, barriers and resistance to change, and to plan how to deal with them. Stakeholders need to fully understand the change so they can have confidence in it

Any new policy is more likely to be implemented if those delivering and receiving the service are aware of the policy and understand that the changes:

- Bring potential benefits
- Are compatible with what is already happening in the organisation
- Have worked successfully in other similar establishments
- Can be implemented in instalments

Communication is a critical activity to build buy-in and to seek feedback when consulting on a draft policy and when implementing the changes. Raise awareness through a range of media, e.g. notices, team briefings, newsletters, etc., and encourage written comments and open discussion

Recognise that it can take time to build appropriate partnerships between the staff groups, and that there is always resistance with new ways of working. Prison operational constraints may compound these further

Identify potential new training and education requirements for staff where new processes are introduced and / or there is limited previous experience with medication in-possession

- A clear understanding of the policy and of the entire process is essential if it is to be consistently and safely implemented
- All staff involved need to feel and be competent in whatever role they play in the process
- Use of local protocols, record keeping and paperwork should be addressed in training sessions
- It may be helpful for key staff to have a placement in a similar prison where in-possession is established
- The needs of agency and locum staff should not be forgotten

Evaluation

Regular feedback to all those involved is important and supports further developments

Local audit and reporting on self-harm incidents and other adverse events in relation to prescribed medicines, both before and after changes to local policies and systems are made, is an important part of the implementation of an in-possession policy

Persistence, resilience and consistency are critical to stay on track through the typical ups and downs of change.

Developing the policy content

Relationship to other policies

Medication in-possession will impact on the delivery of other prison and health care services, and their related procedures, and therefore cannot be considered in isolation. When developing the policy it will be essential for the D&TC to consider how it may fit with, and impact on, other prison policies and strategies so that there is joined up thinking around interrelated issues.

Policies to consider

Medicines management policies may include:

- Prescribing, supply and administration policies in line with good professional practice
- Local prescribing formularies
- Management of long-term conditions and medication review
- Return and disposal of unwanted medicines
- Access to out-of-hours supplies
- Medications available on the canteen list and treatment of minor ailments
- Maintaining accurate and complete medical records, and clinical information management and technology developments
- Mechanisms for identifying and reporting adverse events and drug reactions
- Non-medical prescribing
- Repeat prescribing
- Repeat dispensing
- Use of patient group directions for supply of medicines

Other prison policies may include:

- Drug strategy
- Healthy prison policy
- Searching strategy
- Safer custody policies, which may include some of the following:
 - Violence reduction
 - Suicide prevention
 - Anti-bullying strategy
 - Self-harm management

Duration of supply

In the community, the majority of medicines for long-term conditions are supplied in monthly amounts depending on the condition being treated and relevant patient factors. Some medicines, such as the contraceptive pill and hormone replacement therapy, are supplied for three or six months at a time, whilst others are prescribed for shorter time periods when treating an acute illness or injury. *A Pharmacy Service for Prisoners* (Recommendation 6) recommends that the length of supply of medicines given in-possession should move to be in line with local primary care practice in the NHS.²

Points to consider

- Medicine specific issues. For example, antibiotic course length depends on the condition being treated
- Patient specific issues. For example, an insulin dependent diabetic may prefer to replace his / her insulin when the cartridge is empty / low rather than receive a regular supply based on agreed standard timescales
- Initial duration of supply, and circumstances for approved extensions. For example, it might be preferred to give new arrivals, about which little may be known, an initial shorter supply that can be extended once there has been a period of observation. For more stable and better-known patients, the initial supply could be for longer and then further extended over time as the patient and staff become more confident in the arrangement and concordance has been assessed
- Prescription forms and medicine administration forms will need to be reviewed to reflect changes, to enable prescriptions for chronic medication to be written for a period of up to one year, with the supply of medicines made on a more frequent basis²
- The frequency of prescription review, e.g. a maximum of 14 days for 'as required' and 28 days for all other prescriptions
- Regular medication reviews to ensure patients on medications for long-term conditions continue to gain benefit, and that treatment remains appropriate
- Follow up of patients on short duration treatment to assess concordance, effectiveness of treatment, and to remove and dispose of any surplus medication

Ordering further supplies

Generally, the process involves the patient requesting further supplies in anticipation of running out, which mirrors what happens in primary care, and supports self-care. Medication and prescription review is an essential part of good pharmaceutical care and managing long-term conditions, and should be planned in at regular intervals for all patients who order and receive their medications in-possession on a continuing basis.

Points to consider

- Repeat prescribing and repeat dispensing systems are to be encouraged, in line with those in the NHS,² and should facilitate the re-ordering process
- The method of re-ordering, e.g. a repeat medication request card
- The return of used medication containers prior to the next issue of medications for long-term conditions being supplied
- The process if a patient forgets to request a further supply in advance, and the pharmacy is closed or off-site
- Providing information to all involved to ensure everyone understands the process of re-ordering, and patients know who to contact if they have difficulties or want to discuss medicine-related issues
- Language / literacy difficulties, and the need to ensure dosing instructions and patient information leaflets are understood
- The number of repeat requests allowed before a medication / prescription review is required
- Identification and follow up of any failure to order further supplies, through a medication review, to determine the reason, e.g. non-concordance, unacceptable side-effects, etc.
- How the pharmacy repeat dispensing workload may be made easier to manage, e.g. planned and spread throughout the week

Returning medications

Any medication issued to a patient that is no longer required because of a change in response or in their medical condition, or is not being taken through non-concordance, or is out-of-date, should as a matter of good risk management practice be returned to the pharmacy for safe disposal.

Points to consider

- The process for routinely identifying such medications, e.g. through medication or prescription review
- Whose primary responsibility it is, and which other staff groups may also be involved
- The process and responsibility for returning such medications to the pharmacy
- The need to maintain records of such returns for audit purposes

Medication packaging

Medicines should be packaged and labelled as in normal NHS practice. *A Pharmacy Service for Prisoners*² also recommends (Recommendation 7) that the D&TC should ensure medicines are generally supplied in patient packs. These are the packs in which medicines are supplied by the manufacturer to cover a normal course of treatment — usually a month. Use of these allows labelling and patient information requirements under medicines legislation to be readily met, and is more time and resource efficient to dispense than preparing and packaging into alternative containers. However, there may be some special considerations for the prison service, e.g. where an original pack of medication is a glass container. Just as in the NHS, patients' needs for compliance aids should be individually assessed, and the use of monitored dosage systems targeted appropriately.

Storage of medications in-possession

Thought will need to be given to arrangements for the appropriate and safe storage of medicines in order to minimise risk to other prisoners, and to maintain the integrity of the medicine.² Establishments with in-possession have taken different approaches depending on the status of the prison and its population.

Generally, medicines supplied to patients within institutions, e.g. in hospitals and care homes, are stored in a provided lockable cupboard. This is based on professional recommendations and good practice, as it is not a legal requirement for medicines issued to patients for self-medication, which are appropriately packaged and labelled, to be stored in a locked cupboard.

It is likely to be rare for a patient to need to use medication when on prison based activities, except possibly an asthmatic who may require a bronchodilator inhaler, or an insulin dependent diabetic who may need insulin in advance of meals. The majority of medications are usually taken in the morning or evening, or around meal times, when patients will be back on the wing. (Circumstances for patients in category D prisons who work in the community may be different).

In spite of this, patients may prefer to keep their medication on their person. Those who share a cell may be anxious about leaving any medication in the cell, and wish to hold it themselves or be able to lock it away securely. Some prisons have provided secure lockable cupboards in shared cells, but there are resource considerations. Wing staff may have concerns that an additional locked receptacle in a cell will increase the workload and time taken to conduct cell searches. Transparent lockable safe boxes have been successfully used in American jails, and may reduce the need for search teams to unlock them — although they raise other issues, such as patient confidentiality. Locked cupboards mean that prisoners will hold keys, and the risk of this will need to be taken into account.

A category B local establishment has supplied medications in-possession for a number of years. Cupboard storage for medicines is not provided, but patients remain responsible for their own medication. The view is that it is better to ensure patients have good knowledge of the medication and why they are allowed to have it in-possession.
NPC survey of prisons in England and Wales. Spring 2004 (data on file)

HMP High Down received innovation funding to introduce medication in-possession. They are attempting to use clear plastic storage boxes, as successfully used in American jails.²⁶

Patients in single cells can generally ensure their cell door is closed and hence locked when they leave their cell, which some prisons have decided provides sufficient security, particularly as this is similar to conditions in the community.

There are currently no plans to include secure personal medication storage as part of standard cell design.

The prison is responsible for providing and maintaining items that are fixed to the building, including fixed cupboards and fixed storage.²⁷

Points to consider

- Accommodation types, e.g. shared cells and single cells
- Patient preference regarding storage
- Achievable level of responsibility for own medications, e.g. young offenders and juveniles
- Whether medication should be stored in the cell or retained by the patient
- Whether lockable cupboards are required, and if so, type and funding required
- Impact on security risk
- Cell search implications

Escorts and transfers

There is huge movement within and across the prison estate. In addition, patients are escorted to police interviews and to court, etc. It is recommended (Recommendations 11 and 12) that the policy for medication in-possession and the risk assessment criteria should extend to those patients attending court or being transferred to other institutions or within their own prison.² Close liaison will be needed with local Prisoner Escort Services to develop systems that enable patients to have safe and appropriate access to their medicines, and associated monitoring and administration devices, during escort and transfer.

Obtaining patient agreement

It is essential that the principles and processes of medication in-possession are clearly explained and understood by the patient, and that there is agreement to take responsibility for their own medications. Many prisons use an agreement (compact) that sets out the ground rules and the patient's responsibilities. The patient can take this away to read and digest the details, and raise issues of concern with prison staff. The patient signs the compact giving their consent to take part and commitment to abide by the rules. This consent is usually witnessed by a member of prison staff, and filed appropriately. Special consideration is obviously required around obtaining consent from or for children, and also for patients with learning disabilities.

Medication in-possession:

A guide to improving practice in secure environments

Points to consider

- Compacts for individuals whose first language is not English
- Medication supplied in-possession to a patient is only for his / her own use, and the consequences of finding it in the possession of another prisoner / patient
- The patient's responsibility for ensuring the medication is kept securely at all times, and consequences of failing to do so
- Ensuring the patient is given sufficient information and understands the implications, benefits and risks
- The consequences if medication is lost, e.g. investigate, not automatically replaced, right to in-possession reviewed
- The need for patients to attend a medication review when instructed, and consequences of failing to do so
- Attempts to obtain medication by deception are not acceptable, and the consequences
- Full explanations are given to patients about any changes to, or withdrawal of, medication
- Attempt to store or accumulate medication is not acceptable, and the consequences
- Medication is only to be kept in the container in which it was issued
- Consent arrangements and procedures for children

Managing default or abuse of the policy

Drugs, both prescribed and illicit, particularly those with the potential for misuse, are often a major currency in prisons. Undesirable behaviours such as hoarding, trading, stealing and bullying is common. Prisons have policies and procedures in place for managing a range of undesirable behaviours and these will need to be married with the in-possession policy so that any default and abuse is addressed.

Medication supplied in-possession will be dispensed in a container labelled to identify the medication, the quantity supplied, the date of supply, the person to whom it was issued, with instructions for administration and caution warnings. This means that any medication found out of containers is suggestive of policy default. However, it may not automatically follow that the medicine in the container is as labelled.

Points to consider

- Acknowledge that default and abuse is a potential reality
- What may constitute an abuse or default, e.g. medication hoarding to sell or to self-harm
- How default / abuse may be identified, e.g. over-ordering of medication, via cell searches, etc.
- How patients who default or abuse the policy, or others who cause problems in relation to medication in-possession, will be managed
- Link to those policies that aim to manage undesirable behaviours
- There may be unanticipated medical complications as a result of default, e.g. where medication is not taken and there is a resulting adverse effect on their condition
- Ensure that patients and prisoners are aware of the possible outcomes of adverse behaviour, e.g. placed on Governor report, loss of privileges, etc.

Managing critical incidents

Every process has some associated risk, and changes can lead to shifts in risk. Incidents that arise after changes are made are often attributed directly to the change. However, this may not be the case as the incident may have occurred anyway; so it is important to thoroughly evaluate the incident to determine its root cause before making any response, which may turn out to be inappropriate.

Establishments already have policies and procedures for identifying and managing many types of incident, and have a key performance indicator relating to self-inflicted deaths in custody, and performance standards for the prevention of suicide and self-harm.

Reducing medical errors and improving patient safety are critical issues in health care. It is estimated that around 850,000 incidents and errors occur every year in the NHS, of which medication errors account for around one quarter of incidents that threaten patient safety. A target to reduce by 40% the number of serious errors in the use of prescribed drugs by the end of 2005 has been set by the DH.²⁸ The National Patient Safety Agency (NPSA) was created to coordinate efforts to report, and learn from, adverse events occurring in NHS-funded care. The reporting requirements and procedures in the NHS will apply to prisons.

A Pharmacy Service for Prisoners (Recommendation 18) recommends that prisons have a local system for reporting and learning from adverse patient incidents, including medication errors.²

Points to consider

- Make the local process of reporting incidents easy for staff
- What to report, e.g. self-harm, non-concordance, trading, etc.
- Existing mechanisms of reporting, and any new ones that may need to be developed
- Lines of reporting both locally and nationally
- Links to PCT clinical governance lead and groups
- The types of incident to be reported:
 - Those that have occurred
 - Those that have been prevented (also known as near misses)
 - Those that might happen
- How to share information from all incidents and risk assessments to flag up problem areas and to incorporate the learning into preventative strategies to improve patient care
- Support available from the NPSA, and links to the National Learning and Reporting System (www.npsa.nhs.uk)

Audit and evaluation

Audit should be an integral part of the in-possession policy. It is a key tool for continually improving the quality of services, and should practically guide implementation. It can also highlight any new risks that may have entered the system as a result of introducing or amending an in-possession policy.

Points to consider

- Build audit into the policy and the implementation process
- Conduct a baseline audit with respect to medication-related significant events before implementing or amending the in-possession policy so there is a known baseline
- What other audit information is available to assist, e.g. self harm through overdose reported on Form 213SH; record of hospital bed watches and escorts that may be linked to overdose; cell searching incident reports through security teams
- It need not be time consuming or complicated in relation to medications, and may be built into existing audit processes
- All staff required to collect audit data need to agree to participate
- Findings need to be shared

Risk management and assessment

Risk is associated with any activity, including health care and the use of medicines. When changes are made to existing systems, some risks may be altered and others may be introduced. This is not a reason to avoid making the changes, as inherent risks may already exist within the current system. Indeed not all risk is bad — without certain risks being taken, medicines and the care of patients would not develop and improve. Therefore, taking some risks can be acceptable, but they need to be understood and managed to minimise any unfavourable outcomes.

The prison operational environment is, by its very nature, high risk, and the culture is one of risk management. Prison staff are very familiar with assessing and managing risk, and are aware of the principles involved and the time required.

Introducing in-possession, or enhancing current in-possession policies, may well change known risks and / or introduce new ones. Also, the risks associated with enabling self-care will have to be balanced with those around the duty of care owed to the patient, and with security. These can only be sensibly considered by establishments and their staff through risk assessment and management.

Developing the risk assessment tool

Managing risk is essentially a two-part process:

- Risk assessment is defined as ‘the systematic collection of information to determine the degree to which harm to (self or others) is likely at some point in time’²⁹ i.e.:
 - Which areas have the highest possibility of going wrong?
 - Which of these have the highest possibility of doing harm?
- Risk management is about weighing up those identified potential risks, and then putting systems and precautions in place to minimise the likelihood and severity of harm

Risk management is often shown as four stages:³⁰

- 1 Identification
- 2 Measurement
- 3 Control
- 4 Monitoring

The basic principles include:

- 1 Consider the potential hazards
- 2 Decide who might be harmed and how
- 3 Evaluate the risks, and decide whether existing precautions are adequate or whether more should be done
- 4 Record the findings
- 5 Review the assessment, and revise if necessary

Many prisons have already introduced in-possession, and have developed local risk assessment tools (www.npc.co.uk (Internet), www.npc.nhs.uk (NHSNet) and the **prison service intranet**). However, these generally identify patients for whom in-possession is suitable. The recommendation now is that prisons move towards patients having medication in-possession as standard, and use risk assessment criteria to determine when patients are **not** suitable.

So taking into account this change in default position, the D&TC has been charged with the responsibility for developing risk assessment criteria to determine, on an individual basis, when medicines and related devices **may not** be held in the possession of a prisoner.²

Currently there is no validated risk assessment tool available to perform this function across the prison estate, and it is unlikely that one will be developed that would meet the needs of all prisons and their differing profiles and populations. Therefore, each establishment will need to develop its own tool that takes account of local issues, and that can be easily used to support the decision-making process.

Points to consider

- Ensure the risk assessment tool developed and adopted is fit for the purpose of identifying risk of harm rather than its ease of use
- The tool should help ensure a consistent approach is taken across the establishment, and provide a process for recording how decisions were made
- Issues to be addressed in any risk assessment may vary across the different types of establishment as appropriate to the needs of their population, but will commonly relate to patient, clinical / medication and environment factors (see pages 34-36)
- Involve all relevant staff groups who will be using the risk assessment tool in its development:
 - Their experience will help ensure that all pertinent factors are addressed
 - They may have different needs and preferences for using it in practice that will need to be taken into account
 - To gain ownership and to ensure the tool supports them in their ability to make defensible decisions
- Risk assessment can be perceived as time-consuming and resource demanding, therefore to facilitate its use:
 - Incorporate the use of the tool as much as possible into daily routine functions and processes
 - Make sure it is easy to understand and to use
- Define the trigger points that identify when a risk assessment should be conducted (see below)
- Risk assessment requires a multi-disciplinary approach
- Risk assessment only guides the decision-making process. Define who, or which group, will make the final decision
- The opinion of the patient should always be considered
- Link up with establishments of similar type to share practical experience and learning

When to risk assess an individual?

Amongst the people consulted during the production of this guide, there was much discussion about when the risk assessment of an individual should be done. It was felt that it could be carried out as part of a health care assessment at reception screening in those prisons with a more stable and known population. For others such as local prisons, where little may be known about new patients, and with huge numbers passing through the reception process, this may be both inappropriate and a practical impossibility. However, this debate considered the issue against a background state of 'not in-possession', i.e. the opposite default position to what is now recommended.

There was agreement on the fact that risk assessment in relation to medication in-possession is not a one-off exercise. Both patient and prison circumstances often change, which may change the balance of risk for an individual such that it renders them less suitable for taking responsibility for their own medications. Despite the presence of a signed compact for in-possession, health care and other staff should reassess the patient's continued suitability, and have it formally reassessed where there are any concerns. Therefore, looking at the issue from the point of view where 'in-possession' is the normal state, there needs to be local agreement about the issues and circumstances that would normally trigger a risk assessment of an individual. For example, failure to attend a clinic, when a patient is transferred or when there is a change in sentence status which may alter psychosocial risk factors.

Who should be involved?

All staff members have a role to play in both the implementation of an in-possession policy, and in the risk assessment of identified individuals.

While health care staff are most likely to take the lead, as this is primarily a health led policy, a multi-disciplinary approach is required. Everyone who has contact with a patient / prisoner will have knowledge, and can provide an objective judgement to help inform better risk assessment and management. Staff knowledge about offenders can be vital, but may not be recorded in files. Hence good working relationships and the sharing of appropriate information is important.

The process of risk assessment should make clear how the different staff groups contribute to it. For example, whether decisions are made at team or wing meetings on a face-to-face basis, and alternative ways that staff are able to provide their input.

During the production of this guide, it was highlighted by some staff groups that there might be concerns about the inter-professional sharing of information on individual patients, i.e. they felt that some information could not be shared or recorded due to patient confidentiality. Advice from the Prison Health Team on this issue is that there should be sharing of information between services, as appropriate, while ensuring the maintenance of medical confidentiality in line with professional standards (see also SECURE — A straightforward and practical approach to information rights within prison healthcare).³¹

What factors may need to be considered?

Establishments with experience of in-possession have identified a range of factors that may need to be considered when developing a risk assessment tool for deciding when medication in-possession is not appropriate. These fall into three general categories, and are more fully expanded below:

- Patient-related factors
- Clinical and medication-related factors
- Environmental or local factors

The lists below are not exhaustive. Some factors may not be relevant at all times, some may remain stable over a long period of time, and others may change rapidly depending on the circumstances. Any change in circumstances that may trigger or change the risk assessment status of a patient should be fully documented.

Patient-related factors

- Willingness to take responsibility for own medications
- Cognitive ability to understand medical condition and medication
- Age, e.g. juvenile
- Risk of self-harm, taking into account past behaviour and known current circumstances — such as those prisoners on 2052SH / or identified through ACCT (Assessment, Care in Custody and Team work)³²
- History of drug misuse
- History of trading and / or hoarding
- Vulnerability to violence and / or bullying
- History or tendency to violence and / or bullying
- Antisocial, explosive or impulsive personality traits
- Prisoner status or change in status, e.g. sentenced / remand

Clinical and medication-related factors

- Choice of medication, e.g. tricyclic anti-depressant or selective serotonin re-uptake inhibitor
- Flammability of preparation and potential for its misuse
- Potential for harm from excess or missed doses
- Stability of medical condition
- Monitoring requirements
- Concordance / compliance with previous treatments
- Duration of treatment required, i.e. acute or chronic need

- Frequency of administration, i.e. as required use or regular dosing
- Access to over-the-counter medicines, i.e. from canteen list
- Suitability of medication to be stored in a cell environment
- Suitability of medication packaging, e.g. glass

While the recommendation made is that in-possession becomes the normal position across the prison estate, it may not be appropriate for all medications to be provided in that manner. For example, PSO 3550 Clinical Services for Substance Misusers states that the 'administration and consumption of controlled drugs and other drugs subject to misuse within prison must be directly observed.'³³ The medicines with the highest misuse potential may also have the highest currency value in prisons, so the risk associated with providing them on an in-possession basis may be too great for some patients and some prisons.

Depending on how far down the road establishments are with the implementation of an in-possession policy, different decisions may be made about the same medicine. For example, some prisons are currently content to provide paracetamol in-possession, but others may not be.

The choice of medicine within a therapeutic group is an important consideration for the risk management associated with in-possession, as some are more toxic when misused or overdosed on than others. For example, tricyclic antidepressants are more dangerous in overdose (with the exception of lofepramine) than other groups of antidepressant medicines.³⁴ Many prisons use locally developed formularies for the preferred choice of medication.

In New York State and City prisons, medicines in-possession is the standard approach. The list of medicines considered not appropriate for in-possession include: controlled drugs, anti-psychotics, anti-depressants and tramadol. There are few worries about prisoners using medicines to self-harm.³⁵

The National Institute for Health and Clinical Excellence has published a clinical guideline on self-harm.³⁶ This advises that health care professionals should prescribe, whenever possible, those drugs which, whilst effective for their intended use, are least dangerous in overdose. While this advice is offered to manage self-harm in NHS primary and secondary care, this should be equally applicable to the prison estate.

Alcohol can potentiate the effects of some drugs, and will need to be considered as a risk factor where it is believed that it is being used / misused by patients.

Environmental or local factors

- Single or shared cell, or any change — is the cell mate a risk to a patient with in-possession medicines, or are medicines a risk to a cell mate?
- Extent of movement within prison, and transfers to other prisons or court
- Prison staffing levels
- Local culture in relation to medications
- Arrangements for storage of medications

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These issues will need to be considered and balanced against the medical needs of the patient, and the quality of health care they are entitled to. For example, a decision that medication in-possession is in a patient's best interest might be compromised if the environment, such as a shared cell, precludes a patient being able to participate.

However, many of these factors will be less important in some prisons, for example, prisoners in long stay institutions will be better known to both wing and health care staff, where there is more opportunity for counselling and awareness of health care issues.

Appendix 1

Sources of further supporting information

Prison health

The partnership between the Prison Service and the DH working to improve the standard of health care in prisons has a range of useful publications and guidance for prisons, including the following documents:

www.dh.gov.uk/PolicyAndGuidance/HealthandSocialCareTopics/PrisonHealth/fs/en

- **Clinical governance for prison health: getting started. DH January 2002**
This document sets out some of the key features of clinical governance and offers some practical guidelines on getting started or making further progress
- **Clinical governance — quality in prison health care (PSO 3100)**
This sets out requirements for Governing Governors to ensure that arrangements are being made for clinical governance in prison health care
- **Good medical practice for doctors providing primary care services in prison (PSI 05/2003)**
There are particular issues that confront doctors providing primary care services in prison and this document contains added text enlarging on but not replacing the original text of 'Good Medical Practice for General Practitioners'
- **Guidance on developing local prison health delivery plans (2003)**
Provides guidance around the development of local prison health planning for the two-year transitional period 2004/05 to 2005/06 with a steer that planning arrangements for prison health should be fully integrated and mainstreamed within local NHS and Prison Service planning arrangements from 2006/07
- **Guidance on the protection and use of confidential health information in prisons and inter-agency information sharing PSI 25/2002**
This document provides a framework for developing inter-agency information sharing. Local agreements or inter-agency information sharing protocols will be important in ensuring that boundary crossing processes work smoothly, are effectively managed and that patient and staff uncertainties about information sharing are reduced
- **Health care in prisons: a health care needs assessment**
This document describes the main health problems that exist in the prison population in England and Wales, identifies health care interventions that help meet these health problems, and recommends the health care interventions that should be provided in prisons to meet the health care needs of prisoners
- **Health promoting prisons: a shared approach (PSI 24/2002)**
Aimed at those working with prisoners, and who have a role in promoting health education in prisons
- **Prison health care skills toolkit**
The Healthcare Skills Toolkit is a comprehensive competency-based guidance tool for all prison health care staff, which can be used by Prison Service managers to effectively identify the skills required in their workforce to best meet the identified health needs of prisoners

Change management

- **Developing change management skills: a resource for health care professionals and managers***
This publication and web-based resource aims to help those leading change in health care to use the literature in this field to inform practice by:
 - Describing some of the relevant theories and approaches that have been used to guide change management
 - Illustrating the use of these theories in practice in a variety of settings in health
 - Encouraging readers to reflect on and evaluate change processes and how they might apply these to different settings
- **Making informed decisions on change: key points for health care managers and professionals***
A booklet, drawing on the review, which aims to encourage managers and professionals to reflect on and share what helps and hinders successful change to improve the quality of services
- **Organisational change: a review for health care managers, professionals and researchers***
A review of models of change management to help managers, professionals and researchers find their way around the literature and consider the evidence available about different approaches to change
- **Spreading and sustaining innovations in health services delivery and organisation***
This briefing paper presents the main findings of a systematic review of the literature on the spread and sustainability of innovations in health service delivery and organisation

* The above resources are available at www.sdo.lshtm.ac.uk/publications.htm

- The Model for Improvement is a tried and tested approach to achieving successful change using the Plan Do Study Act (PDSA) cycle www.npdt.org/9748/TheModelforImprovement.pdf
- Information on the PDSA cycle is also available on the national Medicines Management Service Collaborative website www.npc.co.uk/mms/Web_Dev/Collaborative_Area/PDSA.htm

Medicines management

- A guide to good practice in the management of controlled drugs in primary care (England). NPC May 2004
www.npc.co.uk/background_for_cd.htm
- Area Prescribing Committees — maintaining effectiveness in the modern NHS. NPC September 2003
www.npc.co.uk/publications/areaPrescribingCom/apcdocument.htm
- Audit Handbook. NPC January 2000
www.npc.co.uk/publications/auditHandbook/contents.htm
- Essence of care — benchmarks for principles of self-care. Modernisation Agency
www.cgsupport.nhs.uk/downloads/Essence_of_Care/Self_Care.doc
- Dispensing with repeats. NPC November 2004
www.npc.co.uk/mms/extras/dispensing_with_repeats.pdf
- Implementing a community pharmacy minor ailment scheme: a practical toolkit for primary care organisations and health professionals. (N.B. search for minor ailment toolkit)
www.npa.co.uk
- Modernising medicines management — a guide to achieving benefits for patients, professionals and the NHS. NPC April 2002
www.npc.co.uk/npc_pubs_mmm.htm
- NatPaCT competencies for PCTs for medicines management
www.natpact.nhs.uk/competency_framework/SIG/pharmacists/
- Room for review: a guide to medication review. Medicines Partnership and NPC November 2002
www.medicines-partnership.org/medication-review/welcome
- Saving time, helping patients: a good practice guide to quality repeat prescribing. NPC January 2004
www.npc.co.uk/repeat_prescribing/repeat_presc.htm

Prescribing, supply and administration

- Guy's and St Thomas' NHS Trust policy for the development of patient group directions
www.druginfozone.org/Record%20Viewing/viewRecord.aspx?id=523259
- Health Service Circular 2000/026. Patient Group Directions [England only]
www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4004179&chk=KNcufs
- King's College Hospital policy for the development of patient group directions
www.druginfozone.org/Record%20Viewing/viewRecord.aspx?id=523258
- Maintaining competency in prescribing: an outline framework to help nurse prescribers. NPC First Edition November 2001
www.npc.co.uk/publications/CompNurse/maint_compt_nurse_presc.htm
- Maintaining competency in prescribing: an outline framework to help pharmacist supplementary prescribers. NPC First Edition March 2003
www.npc.co.uk/publications/maint_compt_presc/maint_compt_presc.htm
- Mechanisms for nurse and pharmacist prescribing and supply of medicines. DH January 2004
www.dh.gov.uk/assetRoot/04/08/38/92/04083892.pdf
- Misuse of Drugs Regulations — an amendment to the Misuse of Drugs Regulations 2001
www.homeoffice.gov.uk/docs2/hoc4903.html
- Nurse prescribing — DH web pages
www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/NursingPrescribing/fs/en
- Nurse prescribing in substance misuse. National Treatment Agency for Substance Misuse February 2005
www.nta.nhs.uk/publications/Nurse_prescribing_2005_may.pdf
- Patient group directions website
www.nelm.nhs.uk/pgd/default.aspx
- Supplementary prescribing — DH web pages
www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en
- Supplementary prescribing: a resource to help health care professionals to understand the framework. NPC September 2003
www.npc.co.uk/publications/healthcare_resource.pdf
- TO PGD OR NOT TO PGD? — That is the question
www.druginfozone.nhs.uk/Record%20Viewing/viewRecord.aspx?id=503203

Risk management

- **Clinical risk assessment and management policy**
This is a framework for good clinical risk assessment and management of service users in accordance with best practice and national guidelines, and is operational throughout the mental health services in the localities of Tower Hamlets, Newham and City and Hackney
www.elcmht.nhs.uk/pdf/aboutus/clinical_risk_assessment_management_policy.pdf
- Mental health in prisons
www.nelmh.org/home_prison.asp?c=17
- **National Task Force on Violence: self audit tool**
Offers guidance and good practice examples on risk assessment
www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/NationalTaskforceOnViolence/SelfAuditTool/SelfAuditToolArticle/fs/en?CONTENT_ID=4073877&chk=JTdg5a
- Toolkit for health care needs assessment in prisons
www.dh.gov.uk/assetRoot/04/03/43/55/04034355.pdf
- The NPSA was created to co-ordinate efforts to report, and learn from, adverse events occurring in NHS-funded care. www.npsa.nhs.uk/display?contentId=2390 takes you to information on the National Learning and Reporting System. Also find resources on root cause analysis, seven steps to patient safety, and incident decision trees at www.npsa.nhs.uk/health/resources
- Review of risk assessment tools in use in Scotland (including prisons)
www.scotland.gov.uk/library5/justice/svso.pdf
- Risk management of offenders in Scotland
www.scotland.gov.uk/library5/justice/svso-07.asp
- Monitoring the safety and quality of medicines: The Yellow Card Scheme. CSM
<http://medicines.mhra.gov.uk/ourwork/monitorsafequalmed/yellowcard/yellowcardscheme.htm>
- Black Triangle Drugs
<http://medicines.mhra.gov.uk/ourwork/monitorsafequalmed/newdrugs/newdrugs.htm>
- Yellow card adverse drug reaction reporting scheme
<http://medicines.mhra.gov.uk/>

Other useful links

- Centre for Pharmacy Postgraduate Education
www.cppe.man.ac.uk/Miscellaneous/index2.htm
- Centre for Public Innovation
www.publicinnovation.org.uk
- Health Services Management Centre
www.hsmc.bham.ac.uk/prisonhealth/
- HM Prison Service
www.hmprisonservice.gov.uk/
- Medicines and Healthcare products Regulatory Agency
www.mhra.gov.uk/
- Modernisation Agency
www.wise.nhs.uk/cmswise/default.htm
- National Institute for Health and Clinical Excellence
www.nice.org.uk/
- NatPaCT (*organisation no longer exists but website remains available at time of publication*)
www.natpact.nhs.uk/
- National Patient Safety Agency
www.npsa.nhs.uk
- National Prescribing Centre
www.npc.nhs.uk (NHSNet) and www.npc.co.uk (Internet)
- Prison health
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PrisonHealth/fs/en

Miscellaneous

- An insider's guide to the NHS and prison service. Unlocking the jargon
www.dh.gov.uk/assetRoot/04/03/43/56/04034356.pdf
- Glossary of prescribing terms. NPC March 2004
www.npc.co.uk/pdf/glossary_prescribing_terms.pdf
- HSE work on risk assessment: NHS Plus — health and safety at work
www.nhsplus.nhs.uk/Law&you/employers_riskassessment.asp

Appendix 2

Project methodology

The NPC was commissioned by the Pharmacy and Medication Subgroup, Prison Health Team, to develop a framework to support the implementation of Recommendation 5 in *A Pharmacy Service for Prisoners*. This work was supported by the Prescribing Support Unit (PSU).

A steering group was formed to support this project by providing: advice, guidance and expertise; a recognised element to the project structure; and a quality assurance role in respect of project deliverables. The group met twice, in May and September 2004, and conducted further business by email correspondence. Members are listed overleaf.

The project involved:

- An initial joint letter sent from the Prison Health Team and the NPC to all prisons to raise awareness that this work was being conducted
- A questionnaire-based survey sent to all 138 prison establishments in England and Wales during Spring 2004. This was used to identify:
 - How many had developed and implemented a policy for in-possession and how many were in the process of doing so
 - Who was / is involved in developing the policy, and with hindsight who should have been involved
 - What were / might be the main challenges relating to implementation
 - Were / are any challenges unique to the type of establishment
 - What issues would they wish to see addressed in a risk assessment for in-possession
 - Those individuals who would be willing to participate in a focus group
- A baseline survey of risk assessment methodologies and toolkits already available in prisons and the NHS
- Visits to different category prisons and structured interviews with prison staff
- Two focus group meetings, consisting of a wide range of relevant staff from both PCTs and prisons, to highlight the issues that need to be included within the proposed guide
- A user validation group, comprising of potential end users from both prisons and PCTs, to help identify / clarify any further issues, inaccuracies, ambiguities and omissions
- Consultation with key stakeholders
- Dissemination to target audiences

Acknowledgements

Steering group members

Norman Bell	Head of Healthcare, HMP Wormwood Scrubs
Joseph Blackburn	GP Prescribing and Clinical Governance Lead, North Surrey PCT
Richard Chester	Section Head, Prison Transfer, Department of Health
Annie Coppel	Director of Publications and Corporate Governance, National Prescribing Centre (Chair)
John Doohan	Deputy Head of Safer Custody Group, HM Prison Service
Spike Falloon	Safer Custody Group, HM Prison Service
Sue Faulding	Senior Pharmaceutical Adviser, Prescribing Support Unit
Robert Goff	Principal Pharmacist, HMP Leeds
Rebecca Harrington	Section Head — Primary Care and Development Network, Department of Health
Joel Hirst	Quality Improvement Facilitator Medicines and Pharmacy, Bristol North PCT
Cliff Howells	Medical Director, Prison Health, Department of Health
Annette Ireland	Programme / Support Manager, National Prescribing Centre
Carol Lange	Prison Health Pharmacy Lead, HMYOI and Remand Centre Glen Parva
Dave Marteau	Section Head — Substance Misuse, Prison Health, Department of Health
John Reuben	Prescribing Support Pharmacist, Southern Norfolk PCT
Diane Smith	Nursing Adviser, East Midlands Regional Prison Health Development Team
Tee Weinronk	Prison Health Pharmacy Lead, Primecare Forensic Medical Services Ltd
Guy Woollven	Manager F, Security Policy Unit, HM Prison Service

Focus group attendees

Steve Bradford	Deputy Governor, HMP Stafford
Pat Crusher	Staff Nurse, HMYOI and Remand Centre Northallerton
Patrick Drennan	Devon's Prisons Cluster Medical Lead, and GP, HMP Dartmoor
Paul Ferry	Prison Manager, HMP Altcourse
Guy Grant	Health Care Manager, HMP Liverpool
Janet Hambleton	Head of Healthcare, HMP Maidstone
Sue Henson Green	Primary Care Manager, HMP Bristol
Liz Jessop	Principal Pharmacist, HMP Wakefield
Alan Jones	Suicide Prevention Co-ordinator, HMP Liverpool
Justin Lawson	Medical Director (Prisons), HMP Acklington
Gill Maggs	Principal Pharmacist, HMP Holme House
Daniel Matthews	Prison Substance Misuse Officer, Staffordshire County Drug Action Team
Angela Pereira	Health Care Manager, HMP Rye Hill
Frank Purkis	Senior Nurse Manager Lancaster Prisons, HMYOI Lancaster Farms
Andrew Riley	Principal Officer, HMP Foston Hall
Sharon Scottorn	Area Safer Custody Coordinator, Safer Custody Group
Stella Simpson	Principal Pharmacist, HMP and YOI Holloway
Natalie Sissons	Senior Nurse, HMP Whatton

Ron Smith	Pharmaceutical Adviser, East Cambridgeshire and Fenland PCT
Steve Tyman	Healthcare Consultant and Programme Manager (Safety, Health, Decency and Women's Team)
David Wells	Governor for Healthcare, HMP Channings Wood
Sandra Wild	Prescribing Support Technician, Rochdale PCT
Brenda Wilson	Nurse Manager, HMYOI Onley
Rupert Woods	Mandatory Drug Testing Policy Manager, Drug Strategy Unit

User-validation group attendees

John Attard	Head of Healthcare, HMP Pentonville
Andy Bell	Head of Supply, Reduction and Drug Testing, Drug Strategy Unit
Phil Evans	Clinical Director / Medical Lead, HMP Wakefield
Teresa Fairbrother	Dispensary Manager / Chief Technician, HMYOI and Remand Centre Glen Parva
Richard Fifield	Health Care Manager, HMP Swansea
Mike Gibbs	Head of Suicide Prevention Policy, Safer Custody Group
Paul Gosling	Royal College of Nursing and HMP Belmarsh
John Hall	Mental Health Coordinator, HMP Frankland
Julie Hollingworth	Patient Services Pharmacist, Sharoe Green Hospital
Jane Hook	Principal Pharmacist, HMP Lewes
Fiona Hudson	Area Drug Coordinator, Thames Valley, Hampshire and Isle of Wight Area Office
Helen Learney	Safer Custody Officer, HMP High Down
David Logue	Operational Manager Healthcare, HMP Maidstone
Alistair Monk	Principal Pharmacist, HMP Durham
Bob Nicholas	Governor 5, HMP Pentonville
Ann Norman	RCN Adviser — Learning Disabilities / Prison Nursing, Royal College of Nursing
Steve Norman	Development Consultant for Prison Mental Health, SEDC
Jan Palmer	Nurse Consultant — Substance Misuse, HMPS Women's Team
Mary Piper	Public Health Doctor, Department of Health
David Sandell	Pharmacy Manager, HMP Rochester
Dana Tait	Principal Pharmacist, HMP Cardiff

Circulation for consultation

The document (in draft) was circulated widely for comment to a range of individuals / organisations. Those commenting were, or represented, prison health pharmacy leads, SHA prison leads, validation group members and steering group members, professional organisations and prison-related bodies and groups. Comments received were used to further refine the content and presentation of this document.

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National Prescribing Centre
The Infirmary
70 Pembroke Place
Liverpool
L69 3GF

Tel: 0151 794 8134 Fax: 0151 794 8139

Websites: www.npc.nhs.uk (NHSNet) or www.npc.co.uk (Internet)