



Royal College of
General Practitioners

11.11.11



ROYAL PHARMACEUTICAL SOCIETY



The Secure Environment Pharmacist Group



Safer Prescribing in Prisons

Guidance for clinicians
RCGP Secure Environments Group

Purpose of this Guidance:

This guidance is written to assist clinicians working in prisons but it also has relevance for clinicians working in other secure environments. It will be of use to prescribers working in the community whose patients regularly have periods in custody or when a patient is expecting a custodial sentence. Community clinicians should be aware of important prescribing issues in the prison system when patients enter custody. Rationalisation of a patient's care before detention may help the transition into custody and the care provided by the prison healthcare team. Other clinicians who may find the guidance a useful reference are: forensic physicians and custody nurses; consultant psychiatrists; pain clinic prescribers; hospital prescribers.

The authors of this guidance are members of the Royal College of General Practitioners Secure Environments Group. Where possible NICE and Offender Health guidance is followed. Where necessary, to improve upon safety and security within prisons, this guidance has been adapted to meet the needs of the environment and the population it confines. It aims to maintain equivalence of effect, equivalence of practice and equivalence of outcome wherever possible. In doing this a consensus approach, utilising experience gained from working within the environment has been employed.

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Acknowledgements

The authors would like to extend their thanks to Dr. David Rhinds, Consultant Addiction Psychiatrist, and Beverley Berry, RCGP Information Manager, for their editorial support. They would also like to acknowledge the invaluable advice provided by the members of the RCGP Secure Environments Group and of the Secure Environment Pharmacists' Group Executive Committee.

The authors would also like to thank Nottinghamshire Healthcare for its generosity in publishing this document.

This document can be found online at www.rcgp.org.uk and www.nottinghamshirehealthcare.nhs.uk/our-services/forensic-services/offender-health



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Introduction

There are 136 prisons in England. Their primary purpose is to detain in custody individuals proven or suspected of committing a criminal offence. This means that at any one time more than 80,000 individuals are confined to custody and approximately 140,000 people move through the prison system each year. Whilst detained, the majority of these individuals have health needs. It is the responsibility of many separate healthcare teams to meet these needs.

As part of the process that seeks to treat ill health and promote healthier living and the greater wellbeing of patients that are treated within prisons, pharmacotherapy and therefore the prescribing of medication plays an important role. Many prisoners, though not all, are accustomed to using illicit and prescribed drugs to ameliorate or treat symptoms and perceived wants and needs. They may not have considered or tried other types of therapy to improve health and wellbeing. Time spent in custody can be used to encourage prisoners to change their lifestyle and the use of non-drug therapies can challenge the over-reliance on pharmacological treatment.

Medications are misused within prisons. Therefore, medications that may be misused present particular problems within prisons and the wider realm of secure environments as well as in the community.

Within prisons a significant proportion of patients will seek prescribed medication for the psychotropic effect rather than its therapeutic or licensed use. Many of these patients will have a previous history of substance misuse. Prescribing medication where there is no clinical indication is clearly inappropriate and clinicians who prescribe in prisons should understand that medications may be misused. They acquire a commodity value and are often traded within prisons. The acquisition, misuse and onward trading of prescribed medication cannot be supported and should be discouraged as it presents risks in many ways.

Primarily it presents a risk to the individual who is misusing a prescription medication. Misusing multiple medications increases the potential harm to that person. Some treatments may be prescribed to the individual and others may be acquired from the illicit economy within prisons presenting significant risks of harm through overdose and interaction.

The diversion of prescribed medication to the illicit economy that exists also presents risk to the wider prison environment as individuals, groups and gangs within prisons continue in behaviours that may put the safety of other individuals at risk. That risk may come in the form of bullying and threats of assault as an individual is intimidated into diverting a medication prescribed appropriately to them. This coercion may force an individual to divert their medication. They will therefore not receive their own prescribed medication which may have a direct health consequence and that medication could be diverted into the illicit economy, thus presenting risk to the wider prison population.

The trading of prescribed medications also puts individuals at risk through the accumulation of debt and this debt may cause significant risk to personal safety and may also impact on a patient's physical and mental health.

Methods of diversion of medication are varied and the risk of diversion is mitigated by limiting the amount of medication that a particular establishment would allow the patients to keep 'in possession.' Medication is usually dispensed supervised by individual dose, daily, weekly, monthly or at other recognised intervals depending upon the type of drug, patient factors and security factors within the prison. Some medication is administered in a supervised manner in prisons.

Within certain types of prisons (Local remand prisons, Category A and B establishments) a significant proportion of the medication prescribed is administered at pre-set times via centralised or wing based dispensaries. This is usually when diversion occurs and may take the form of simply pocketing medication or doses may be concealed within the mouth and be removed later and sold. Sometimes medication is regurgitated as in the case of 'spit methadone' and there have been reports of saliva being dried to allow the diversion of sublingual preparations of particular medicines to enter the illicit economy. Prescribers should not use 'daily in possession' packs where there is significant risk of diversion, and as a means of preventing self-harm they offer only marginal benefit over 'weekly in possession' supply.

Considering these issues, clinicians who work within prisons should be aware of patients presenting with exaggerated or fictitious disorders in an attempt to gain a prescription for a medication they do not require with an intent to divert this medication into the illicit economy of the prison.

Clinicians who choose to work within prison should also be familiar with the requirement of mandatory testing of prisoners for drugs and they should consider whether their prescriptions could mask illicit drug use, particularly with regard to the prescribing of opiates.

Since the responsibility to commission health care services within prisons transferred to PCTs in April 2006, there have been improvements in the quality of the services delivered within prisons. The standard of care should be equivalent to

the standard that is delivered in the community. This equivalence is fundamental, but equivalence does not imply 'sameness.' Prisons are complex environments with challenging populations and in providing equivalence some areas of health delivery should be adapted to mitigate risk. The choice of medication is one area where clinicians who work within prisons should consider equivalence carefully. It is appropriate that this occurs as the clinician has responsibilities, not only to the patient, but to the wider prison community. They have a responsibility, through prescribing appropriately for the environment in which they work, to reduce risks to the wider prison population.

The specific detail of how a prison seeks to reduce the inherent risks with medication use and abuse within its confines should be decided on a prison by prison basis. It should be inclusive of Prison Service Orders and Instructions, and it should also reflect the category of the prison itself. Further to this, the nature and behaviours of the population that the prison confines should be taken into account. Engagement with the Drug Strategy Team at the prison to understand the local issues can provide a co-ordinated approach to mitigating risk. The clinical governance of prescribing policy should be overseen by the commissioning organisation.

When an individual treatment is being determined, decisions should be individualised to the patient so that the particular need of the patient is met, while the duty to reduce risk to the prison population is fulfilled.

The principles for mitigating this risk are not complicated but they may incur additional costs. The increased cost of providing services within a secure environment may be an appropriate expenditure for a healthcare provider to undertake and this should be recognised within prescribing budgets. The involvement of a pharmacist experienced in secure environment practice can optimise risk mitigation and ensure cost-effective use of the most appropriate pharmaceutical form of medication.

The principles of reducing the risks of medications are choice of preparation; form of the preparation; use of an alternative; and occasionally the use of an unlicensed medicine. The GMC recognises that in certain situations doctors prescribe unlicensed and off-label preparations where good evidence exists of their benefit and their use in the particular circumstances can be justified. Injectable preparations when administered do not get diverted and they ensure compliance. Therefore depot medications may be an option in certain circumstances.

The change of preparation from a standard release tablet based medication to a modified release tablet or even a liquid based medication reduces the potential for diversion. Capsules may cause

problems as the medication comes in a form that is readily diverted, the capsule opened and the powder or granular contents may be injected or snorted.

In the following pages, the most common medications misused within prisons are considered and rated for their general suitability for use within a secure environment. There are of course local circumstances which may override these recommendations. This guidance does not deal specifically with the integrated treatment of drug users or the management of palliative care in prisons. The authors have used a traffic light system to evaluate medicines, with regard to the risk of use in this environment.

Red medicines

are generally considered to be inappropriate in prisons as their misuse potential and their potential for harm is considered unacceptable and alternative medications are available. They carry the highest risk if used and they should only be considered where alternatives are not available.

Amber medicines

should usually only be considered as a treatment when other choices are inappropriate or have been used unsuccessfully. Even in this circumstance they should be prescribed with caution. Amber medications have a recognised abuse potential and experience from the prison estate supports the assumptions that these medications are abused in practice. Their abuse should not be supported but the risk of individual harm is arguably less than the red category. For a prison population as a whole though, the risk associated with widespread trading may not be reduced and widespread use of amber medications should be considered as inappropriate within a particular prison. In limited circumstances amber medications may be prescribed as first line treatments but their potential for abuse remains high. An example of this is benzodiazepine withdrawal treatment.

Green medications

carry lower risk and where possible after assessing individual need and prison factors these medications would generally be a first choice treatment. To facilitate these medications as first choice treatments, they may need to be used off licence or outside of NICE guidance.

It should be noted, that in balancing the risks of the environment and the risks of a particular medication against the needs of an individual, it may be appropriate to prescribe a medication that is outside of accepted community guidance and practice. It is defensible and appropriate to do this in circumstances where equivalence of care is being sought, having carefully considered and documented this risk evaluation.

This guidance identifies the most problematic drug groups and preparations. It considers some of the key issues and links these to national guidelines and evidence to support prescribing decisions.

The guidance is intended for all prescribers working within prisons, particularly those with less experience of this specialist area of practice. The guidance will also be of value to primary care prescribers in the community who provide care for patients with addiction and forensic problems and also to those prescribers in secondary care where, either on an out-patient or in-patient basis, their patients will return to a custodial setting. The guidance does not include every preparation in a class nor should it be regarded as exhaustive in covering every prescribing issue related to the drug groups.

Additional Resources

This document updates and enhances advice given on the NELM website in 2008.

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ECG monitoring

Royal College of Psychiatrists. Consensus statement on high-dose antipsychotic medication Approved by Council: October 2005. Due for review: 2008 Council Report CR138. London: Royal College of Psychiatrists, May 2006. <http://www.rcpsych.ac.uk/publications/collegereports/cr/cr138.aspx> [accessed 04 July 2011].

Possession of Medicines

In June 2003, as part of a wider programme to bring improvements in health care delivery to prisoners, HM Prison Service and the DH (Department of Health) jointly published 'A Pharmacy Service for Prisoners'. Recommendation 5 states:

'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, for determining on an individual basis when medicines and related devices may not be held in the possession of prisoners'.

In addition, Prison Service Order 3550 and PSI 45/2010 require that:

'All drugs liable to misuse within the prison setting must be administered under supervised conditions'.

Many drugs with central nervous system effects are sought by prisoners with a history of drug taking or chronic drug misuse. Prescribers should be aware that they may be manipulated to prescribe these drugs where there

is not a genuine indication. In addition, prisoners with an identified need receiving these drugs may be bullied to divert the drug to others. Prisoners should be risk-assessed and regularly reviewed to ensure that they receive their medication in the most appropriate way for the safety of the individual and the safety of the wider prison community.

All prisons are expected to have a local policy regarding medication. That policy should follow national guidance but be localised to the specific establishment and the nature of the population that it confines. The aim of that policy is to form a balanced approach respecting the autonomy of the individual patient and promoting that autonomy in the context of patient safety. Such medicines management policy also forms a method through which individual prisons can demonstrate the mitigation of risk in respect to both health service provider and establishment.

When prescribers are considering an appropriate form or dosage regimen of medicine for those patients who have been risk assessed to receive their medication 'Not In Possession', they will need to take into account the restrictions of the custodial regime with regard to timing of dosing, availability of medicine administration times and other factors that may affect their choice. Use of modified release preparations that require once or twice daily dosing can ensure optimal treatment is provided with reduced risk. The pharmacist is a useful resource for finding out the range of preparations available.

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HM Prison Services. Integrated Drug Treatment System. PSI 45/2010. London: HMPS, 2010. <http://www.hmprisonservice.gov.uk/resourcecentre/psispsos/listpsis/> [accessed 01 July 2011].

Pain

Within prisons the incidence of patients requesting treatment for pain is high and clinicians who issue these prescriptions should be aware of the abuse potential of prescription drugs. Clinicians should be acutely aware of the problems associated with analgesia abuse and dependence. The main area of concern is opiate based analgesia.

It is not appropriate to fully exclude the use of weak and strong opiates as this would encourage over reliance on non steroidal anti-inflammatory drugs which carry their own risks of use and without recourse to opiate medication patients may be left with genuine pain that is under treated. However consideration must be given to the addiction potential of opiates, particularly in those patients with a tendency to addictive behaviours. Opiate analgesia should be prescribed for as short a period as possible. It is noteworthy that despite initial guidance that tramadol was safer and less addictive than existing opiates, post marketing evidence now shows that the drug possesses similar risks to the more traditional opiates, and also additional risks relating to its effect on other biochemical receptors.

The use of opiate based medication is particularly problematic within prisons as access to stronger illicit opiates is reduced to a certain degree. Although one would reasonably assume that the expansion of substitute prescribing across the prison estate would eradicate or minimise this, experience shows that despite opiate substitution prescribing, opiate medication abuse, particularly but not exclusively, in the form of prescribed weaker opiates is still common place. Dihydrocodeine, codeine and tramadol are misused both for their euphoric potential and their sedative effect and are very popular with heroin users, as they also alleviate opiate withdrawal. As these medications have well recognised abuse potential, they have acquired significant commodity value within many prisons and their diversion and misuse puts vulnerable individuals at risk of coercive diversion. Clinicians who work within a prison should therefore be mindful of the risks to the wider prison population when prescribing opiate based analgesia whilst discharging their duty of care to a particular patient who is expressing pain symptomology. These preparations are widely misused throughout society.

This risk to the wider prison population is reflected within prison service orders/ instructions. PSO 3550 and PSI 45/2010 require that medicines subject to abuse should not be held in possession within prison, and clinicians can mitigate the risk further by consideration of medication formulation when the prescription of an opiate based analgesia is considered appropriate. An example of this would be the prescription of soluble or effervescent medications to reduce the risk of diversion at supervised consumption. Mitigating risk by offering alternative formulations of the same medicine does carry cost implications and this should not form an undue barrier to providing a specific medication where other alternatives are not available. Soluble opiates may be less suitable in patients with hypertension and heart disease because of the high sodium content.

Specific consideration should be given to the appropriateness of prescribing opiate based medication within a consultation and whether an alternative medication or adjuvant could be utilised for an individual presentation of a patient. Whilst not advocating under-treating genuine pain, clinicians should be aware that expressing symptoms of pain is one method of eliciting opiates for misuse and the assessment of reported pain should be the subject of continuous rigour from the clinician. In providing an opiate prescription a clinician may be initiating, legitimising or facilitating an opiate dependency.

Prescribed opiates may also be used to mask the continued use of illicit opiates and therefore confound systems used by a prison such as mandatory drug testing in reducing illicit drug use.

Clinicians should actively avoid the perception of collusion with a patient whilst maintaining treatment that is appropriate to the environment and in the patient's best interests.

Dihydrocodeine has historically been used within prisons as a detoxification agent and in police custody as symptomatic treatment. It still maintains strong associations in prisons with the substance misusing population. It is generally an inappropriate analgesic where individuals have a history of substance misuse even if an individual has entered recovery. Individual establishments should consider via their medicines management committees whether dihydrocodeine should be within the prison medication formulary and this decision should reflect the nature of the population that the prison confines.

With increasingly ageing populations detained within prisons, analgesic patches are being used to control chronic and cancer based pain with increasing frequency. The use of these patches presents the clinician with further considerations as prison health care providers have experienced patients abusing the analgesic patch through 'sharing' the patch with others. Therefore checking the site of the patch may be considered as a method of monitoring risk and patches can be covered with secondary dressing to help maintain their security. The Summary of Product Characteristics must be checked for the individual product if this is being considered to ensure that this practice is not known to affect the absorption profile of the patch. Additionally, patches which are non matrix patches and therefore contain a reservoir of strong opiate medication are not appropriate for use within secure environments as diversion of the liquid presents a significant risk to individuals.

The use of novel delivery methods of strong opiates, such as 'lollipops,' presents a significant risk of abuse within prisons. The patient to whom this formulation of medication is prescribed may be at risk of bullying. When recommended by a consultant, their use within prisons should always be within a comprehensive support and security

package to minimise the risk to an individual who would normally be considered vulnerable as a consequence of a disease process. The use of 'lollipops' is discouraged and the use of alternative analgesia delivery methods advocated. It can be helpful to discuss with pain clinic consultants the significance of their choice of analgesic product as they may be unaware of the implications within a secure environment.

The management of acute pain within prisons may also lead to prescription medication dependency if treatment plans are not specific, documented and adhered to. All prescriptions of opiate based medication should be subject to regular review to determine whether the continued prescription is appropriate. In the case of chronic pain, clinicians may consider the planned use of opiate holidays with suitable alternative analgesia to help minimise the possibility of prescription opiate dependence.

Tramadol is licensed for moderate to severe pain but is not as effective as strong opioids for severe pain being roughly equivalent to codeine in strength. Nausea, dizziness and constipation are common side effects (although nausea and constipation may be less severe than with codeine); hallucinations, confusion and convulsions, as well as cases of drug dependence and withdrawal, have been reported with tramadol at therapeutic doses. The Committee on Safety of Medicines (CSM) advises that treatment with tramadol should be short-term and intermittent, and caution is required with patients with a history of addiction or dependence. Caution is also required with patients with a history of seizures and those taking drugs that lower the seizure threshold. Tramadol has a more problematic profile than other weak opioids because of its additional activity on other receptors which cause enhanced risk of withdrawal effects. It is no more effective and may be less suitable for use in the prison population and it should only be prescribed after a clinician has considered alternative analgesia and weighed risks of the prescription in terms of safety within the environment and the diversion potential into the illicit market. Specific establishments, through their medicines management committees may take a

view that tramadol is not appropriate for use within a particular environment.

Despite these considerations clinicians may encounter situations where a patient is inappropriately asking for opiates or situations where an existing opiate prescription could be being diverted to the wider prison population. In situations such as this it is advised that voluntary clinical urine drug testing using a detailed hospital laboratory analysis is undertaken. Where this is not possible Point-of-Care testing (POCT) kits for Tramadol, Buprenorphine, Methadone and other illicit drugs are available and can be used as an alternative means of checking for compliance. Tramadol will not be detected by these tests for 'opiates'.

The observation histories of third parties such as wing officers, nurses and gymnasium instructors may also be considered when making a balanced decision as to the continuance of an opiate analgesia prescription in the context of reported pain or impaired function where there is clinical doubt about the use and indication for an opiate analgesic, without compromising a patient's confidentiality. This can allow for a more objective assessment of function and improvement than that provided by the patient alone.

In general, the management of pain within a secure environment should follow the same principles as the management of pain within the community. It should follow a stepwise approach in line with

the World Health Organisation analgesic ladder model. It is only the medications and in some circumstances the formulations that may need a specific approach.

Nefopam is a non-opioid centrally-acting analgesic for moderate pain. The evidence base is limited, however it may have a use where other non-opioid analgesics are ineffective, but sympathomimetic and antimuscarinic side effects may be a problem.

The value of complementary therapies should be emphasised and these, where available, may produce analgesic sparing effects.

It should be recognised that some patients may become depressed as a result of imprisonment with a corresponding reduction in their pain threshold. Complementary programmes and self-help courses which have a holistic approach with self empowerment as a substantial part of the therapy may be particularly helpful. Therapists may be available in prisons to help with pain relief and lifestyle changes.

Cyclizine should be avoided in patients who use opiates illicitly due to well reported hallucinatory symptoms.

The management of palliative care in prisons is a rapidly developing area which presents important considerations for prison health care teams and prisons themselves. This guidance does not consider the specific issues pertaining to prescribing in palliative care within a prison.

Medication	Place in therapy	Environmental considerations	Category
Paracetamol	In accordance with the analgesic ladder.	Has an association with deliberate self harm by overdose which should be considered in patients at risk of self harm. Abuse potential low. Can be purchased over the counter in many prisons.	
NSAIDs Ibuprofen, Naproxen	In accordance with the analgesic ladder.	Nil of note. Can be dangerous in overdose. Risks of gastrointestinal ulceration and bleeding.	
Nefopam	Consider before opiate analgesia in selected individuals where other non-opioid analgesics ineffective. Limited evidence base of effectiveness.		
Codeine	Short duration use in patients who do not have opiate addiction problems.	Special care in patients with substance misuse histories. Consider dispersible/ effervescent preparation with 'co' preparations.	
Tramadol	Consider after Paracetamol, NSAIDs, Nefopam and adjuvants in selected individuals (see notes above).	Special consideration in patients with substance misuse histories. May be considered as a 'red' medication in some establishments.	
Strong opiates: Morphine, Fentanyl	Strong opiates are indicated in severe pain. They should be prescribed when indicated.	The prescribing of strong opiates to vulnerable, sometimes debilitated patients places them at risk of bullying. When prescribed this should be as part of a comprehensive treatment plan which also encompasses specific security concerns.	
Dihydrocodeine	Avoid in patients with substance misuse histories.	Special consideration in patients with substance misuse histories (with caution some prisons may consider this an amber medication).	
Pethidine	Very limited indications for Pethidine.	Strong opiates in tablet form present a significant risk of abuse.	
Fentanyl 'lollipop'	Generally not appropriate. Consider other options.	Significant diversion potential.	

Opiates and other controlled drugs which are highly toxic in overdose should be carefully stored in prisons in line with Home Office regulations. Prisoners have died in certain situations having obtained the keys to the prison drug cupboard.

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Neuropathic Pain

The international association for the study of pain defines neuropathic pain as “pain arising as a direct consequence of a lesion or disease affecting the somatosensory system”. Common examples of neuropathic pain syndromes are post-herpetic neuralgia, diabetic neuropathy, nerve entrapment syndromes, phantom limb pain, spinal cord injury, prolapsed disc, stroke, Multiple Sclerosis and Parkinson’s disease.

There is no standard diagnostic procedure for diagnosing neuropathic pain. The essential elements of the process are to identify painful symptoms, altered sensation and a clinical history that all match a neuro-anatomical or dermatomal pattern. Examination should identify altered sensation in the painful area. Numbness is often present in the dermatomal area and exaggerated painful response to pinprick testing.

In the prison setting, pregabalin and gabapentin are highly sought after because of their use in enhancing the effects of opiates and their own inherent abuse potential. In NICE guidance CG 96, gabapentin is not recommended for primary care prescribing but its use remains common and it is a licensed indication.

Some of the difficulties with the treatment of neuropathic pain arise from inappropriate use of neuropathic analgesia for non neuropathic conditions or from sub optimal assessment by the initiating clinician leading to unnecessary prescribing.

As with analgesia guidance, information obtained from wing, gym and healthcare staff may be helpful in determining an independent assessment of the patient’s mobility to differentiate from a desire to obtain medication for trading or illicit use.

There is no clinical indication for the use of gabapentin and pregabalin for non-specific mechanical back pain which is often encountered in patients in prisons. Such prescribing causes problems for clinicians trying to withdraw an inappropriately prescribed drug in a different establishment. In this clinical situation physical and complementary therapies such as physiotherapy or remedial gym should be considered.

Furthermore, if patients are referred for a specialist opinion GPs should be aware of the importance of providing an appropriate history of addictive behaviour in patients referred to pain clinics who are at risk of being prescribed these drugs inappropriately.

Medication	Place in therapy	Environmental considerations	Category
Amitriptyline (also Nortriptyline and other TCAs)	First line Advantage of once daily dosing (Unlicensed indication).	TCAs have significant commodity value as a result of their sedative effects. They are dangerous in overdose but risk can be lessened by closely supervised consumption.	
Duloxetine		Minimal abuse potential. Has a licence for use in diabetic neuropathy and may be beneficial in other forms of neuropathy.	
Gabapentin	Second or third line.	Recognised abuse potential. Special consideration in patients with substance misuse histories.	
Pregabalin	Second or third line.	Well recognised abuse potential. Special consideration in patients with substance misuse histories.	

Second Line treatments

If pain reduction is not satisfactory with first line treatment at the maximum dose, consider combination or alternative therapy and re consider the primary diagnosis.

Third line treatment

- If pain reduction is not satisfactory with second line treatment, refer to a pain specialist.
- While waiting for the consultant opinion, consider oral opiate in combination with the second line treatment or as a replacement for the second line therapy. (Strong opiates should generally not be initiated by a primary care doctor in these circumstances).

Consider topical lidocaine for localised pain, however, this is only licensed for post-herpetic neuralgia.

It cannot be overstated that in prisons, the appropriate assessment of neuropathic pain is fundamental in the prescription of any analgesia as a comprehensive assessment will reduce inappropriate prescribing. The prescriber should be aware that a proportion of prisoners have been known to fabricate symptoms of neuropathic pain to gain access to these drugs and that they may have a comprehensive knowledge of the relevant signs and symptoms.

If illicit drug use is suspected or non-concordance or diversion possible a detailed urine drug screen is recommended.

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Resources:

NICE. Neuropathic pain: the pharmacological management of neuropathic pain in adults in non-specialist settings NICE clinical guideline CG96. London: NICE, 2010. <http://www.nice.org.uk/guidance/CG96> [accessed 01 July 2011].

Depression

In assessing depression, in addition to clinical judgment, the use of standardised assessment tools may be of value. Antidepressant medication should be considered in moderate or severe depression. Previous treatment failure or success should be considered when considering which antidepressant medication to use. Where an antidepressant is not advocated for general use within a secure environment, an alternative medication with a more acceptable safety profile and lower abuse potential should be considered after an appropriate washout period where this is necessary.

Consider psychological therapies at all stages of depressive illness. Prisons should have good access to mental health services and these resources should be used in patients presenting with depression.

When treating depression within prisons clinicians should be aware of the reported link between suicidal risk, depression and antidepressant therapy. Young adults and patients with a history of suicidal behaviour are particularly at risk and where necessary patients should be monitored closely for suicidal behaviour. The prison process of ACCT (Assessment, Care in Custody and Teamwork) may be valuable in this respect, and a joint approach between custody and healthcare staff is best practice. When considering suicidal risk in initiating antidepressants clinicians should also be aware that juvenile depression is itself a strong risk factor for both attempted and completed suicide, and that any decision to use antidepressants needs to balance the known risk of increased suicidality secondary to a depressive disorder against the apparent increased risk that may be attributed to the use of an antidepressant itself.

The potential for abuse is linked to experience from the environment, known euphoric side effects and known sedating side effects. Where information is limited class effect is inferred.

When prescribing in a secure environment clinicians should be aware of the following points;

1. When prescribed preference should be given to orodispersible formulation.
2. BNF 60 September 2010 states 'There is little to choose between the different classes of antidepressant drugs in terms of efficacy, so choice should be based on the individual patient's requirements, including the presence of concomitant disease, existing therapy, suicide risk and previous response to antidepressant therapy. SSRIs are better tolerated and are safer in overdose than other classes of antidepressants and should be considered first-line for treating depression'.
3. When augmentation with neuroleptics is being considered, it should normally only be considered by a psychiatrist or in liaison with a psychiatrist. Augmentation with buspirone is appropriate by primary care doctors with appropriate training and experience.

4. Where the usual maximum BNF stated dose, given 'In Possession' for one week or longer, ingested in an act of self harm in a 70kg individual should result in a hospital admission as recommended by Toxbase, then the risk of In Possession provision should be specifically considered in any prescribing decision. This consideration is separate to the risk inherent in abuse and is not covered by PSO 3550 and PSI 45/2010. Individual policy regarding which medications can be kept in possession should be determined at establishment level in conjunction with the medicines management committee. It should reflect the population which the prison confines and allow for exceptions beyond the guidance stated above.
5. Mirtazapine: Although mirtazapine use may be appropriate within a secure environment, any prescribing decision should take into account the medication's links with substance misuse where it may be taken simply as a form of night sedation. As a result of the sedation caused by the use of mirtazapine, it is frequently requested by name by patients. It has definite potential for diversion and patients in receipt of mirtazapine may be subject to bullying. All these potential pitfalls should be considered in any prescribing decision. When prescribing is considered appropriate it should be prescribed in an orodispersible form only. Urine drug testing should be considered to ensure compliance and the absence of illicit opiates. It should only be prescribed second or third line in major depression. Morning administration may reduce its popularity.

Medication	Place in therapy	Environmental considerations ¹	Category
Fluoxetine	1st line in depression - (Caution in epilepsy, Cardiac disease, Diabetes mellitus). Bulimia nervosa, OCD.	Euphoria is a recognised side effect, but few reports of significant abuse. Possible increase in suicidal ideation after initiation. Available in a liquid formulation.	
Citalopram	1st line in depression (Caution in epilepsy, Cardiac disease, Diabetes mellitus). Panic disorder.	Euphoria is a recognised side effect, but no reports of significant abuse though less alerting than Fluoxetine. Available in a liquid formulation. Adults who have ingested 3mg/kg should be referred to hospital.	
Paroxetine	2nd line in major depression OCD, PTSD, Panic disorder.	Low potential for abuse. Available in liquid formulation Symptoms of toxicity may be delayed as absorption is slow. Ingestion of 100-800mg have resulted in only minor symptoms. Adults who have ingested 3mg/kg should be referred to hospital. Recognised problems withdrawal.	

Escitalopram	2nd line in depression (Caution in epilepsy, Cardiac disease, Diabetes mellitus). Panic disorder, GAD, social anxiety disorder.	Available in a liquid formulation Little information is currently available but toxicity is expected to be similar to Citalopram.	
Sertraline	2nd line in depression (Consider 1 st line post MI and epilepsy). OCD PTSD	Low potential for abuse.	
Trazodone	2nd line in depression	Sedation is typical, therefore diversion and trading is likely. Available in a liquid formulation Doses of 2-3g have caused convulsions and respiratory arrest. Death has been recorded after ingestion of 4.5g.	
Mirtazapine	2nd or 3rd line in Major depression ONLY	Sedation is typical, therefore diversion and trading is likely and has been widely reported in prisons. IT SHOULD NOT BE PRESCRIBED AS A SLEEPING TABLET Available in orodispersible form Less toxic in overdose than other antidepressants. NO serious adverse events other than sedation and slight tachycardia reported.	
Venlafaxine	2nd line Major depression GAD	Seizures are common after ingestion of 1.5g but have been documented with ingestion of 375mg. Death has occurred at ingested dose of 8.4g.	
Amitriptyline	Generally should not be used as an antidepressant. Lower doses may be considered in neuropathic pain (unlicensed) or migraine prophylaxis (unlicensed) At lower doses Amitriptyline may be considered AMBER .	Patients should be offered alternative treatment Tricyclic antidepressants are very toxic by ingestion. Normally ingestion of 15 mg/kg would be expected to result in serious, potentially life-threatening symptoms. Fatalities have occurred at doses >15 mg/kg.	
Dosulepin	Depression	Patient's should be offered alternative treatment Dosulepin is more toxic than other TCAs and has a mean dose causing convulsions of 1.9g compared to 3.0g for other TCAs. May induce life threatening cardiac arrhythmias.	

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PHQ9 and HAD

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PRIME-MD® Patient Health Questionnaire © 1999, Pfizer Inc. Reproduced with permission. Copyright © August 2003 Caremark.

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Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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Epilepsy and Other Convulsive Conditions

Alcohol withdrawal, substance misuse, head injury and associated learning difficulty are common amongst the prison population, hence epilepsy is said to be more common amongst this group than in the general community. Research has not, however, confirmed this. The reported rate of epilepsy in a 2002 meta-analysis was 0.7% in prison compared to 1% among young adult males in the UK¹.

Antiepileptic medications can be desirable drugs of abuse as many of these drugs have sedative side effects. Doctors are understandably cautious about altering patient reported prescriptions. As with any prescribing in a secure environment, it is essential to seek confirmation of any prescription before medication is continued on a repeat basis².

It is important to seek confirmation of a diagnosis of epilepsy for any prisoner claiming a history of epilepsy and where confirmation cannot be gained from the community general practitioner, neurological referral may be appropriate.

Whilst the desirability of abuse with these medications may suggest that prescribers only give these medications by supervised consumption the need to optimise concordance is important and to best prepare the patient for life in the community 'in possession' should not always be disallowed.

Patients may report being prescribed clonazepam for epilepsy to access a prescribed benzodiazepine. This is widely recognised in prisons and prescribers need to be aware of this. Clonazepam is difficult to identify in laboratory urine testing which further complicates the supervision of its use. It may be possible to discontinue clonazepam where there is no indication, after confirming that this is an inappropriate medication with relevant colleagues. Clonazepam should not be used as monotherapy and when presented with this scenario, a clinician should consider more appropriate management where epilepsy has been confirmed.

Gabapentin and pregabalin (see also neuropathic pain) are also commonly requested by drug misusers for "nerve pain" resulting from old injuries as well as for epilepsy. These drugs also have benzodiazepine type anxiolytic effects which make them desirable to this group of patients. Their use in epilepsy is diminishing.

Epilepsy is not a condition that should be diagnosed and managed by a primary care doctor without recourse to a neurologist. Although a typical history may be suggestive of the diagnosis, the definitive diagnosis should be made by a neurologist after appropriate assessment. Unless fit frequency prevents this, it is good practice to allow the neurologist to advise on the initiation of specific treatment once the type of seizure has been elucidated and a diagnosis made.

The Quality and Outcomes Framework (QOF) in the community requires review of epileptic patients' medication and fit frequency and may prompt specialist review or form the framework by which a clinician could review the primary diagnosis and its management. Abrupt withdrawal of any anti epileptic drug prescribed for epilepsy should be avoided as this may precipitate rebound seizures. When withdrawal is undertaken, this process should be protracted and closely monitored.

Medication	Daily dose range	Prescribing notes and environmental considerations	Category
Carbamazepine	100mg-2g divided doses	Epilepsy, mood stabiliser and neuropathic pain. Use of modified release preparation significantly lessens the incidence of dose-related side effects. Can cause blood, hepatic or skin disorders – monitoring for signs is essential. Use with caution in patients with history of haematological reaction to other drugs. Available in liquid form	
Sodium Valproate	600mg-2g	Epilepsy and mood stabilisation (often given as Depakote - Semisodium Valproate). Monitor liver function in first 6 months. Available in liquid form	
Phenytoin	150-500mg	Used less frequently since the introduction of less toxic alternatives. Skin, gum and blood abnormalities possible. Available in liquid form	
Lamotrigine	25-200mg	Partial and generalised seizures – monotherapy and adjunctive. Unlicensed use in trigeminal neuralgia and bi-polar affective disorder. Serious skin reactions including Stevens Johnson syndrome. Also risk of serious blood disorders including DIC. Available in dispersible tablets Not widely abused.	
Topiramate	25-800mg	Monotherapy and adjunctive therapy. Migraine prophylaxis under specialist supervision. May cause suicidal ideation and nephrolithiasis. Not widely abused.	
Levetiracetam	250-3000mg	Partial and generalised seizures – monotherapy and adjunctive. Side effects may include abdominal pain and vomiting. Rarely psychosis and suicidal ideation. Not widely abused.	
Vigabatrin	1-3g	Adjunctive treatment in partial / secondary generalisation. Visual field defects may develop Available as a powder for dissolution in water Not widely abused.	
Gabapentin	100-2700mg	Partial and generalised seizures – monotherapy and adjunctive. Neuropathic pain. Unlicensed use in trigeminal neuralgia. Extensively abused by drug users and high trading value ⁴ .	

Medication	Daily dose range	Prescribing notes and environmental considerations	Category
Pregabalin	25-600mg	Partial and generalised seizures adjunctive treatment. Neuropathic pain. Generalised anxiety disorder. Extensively abused by drug users and very high trading value ⁵ .	
Clonazepam	0.5-8mg	Status epilepticus, myoclonus and other forms of epilepsy. High diazepam equivalence. Extensively abused by drug users and very high trading value. RED if being considered for monotherapy	

Diazepam is not appropriate for maintenance monotherapy in epilepsy.

Diazepam remains a popular drug of misuse and patients may relapse when they withdraw from significant dependency. In this particular situation it is important to appropriately treat the diazepam dependence following substance misuse national guidance. If the patient has a seizure a secondary care opinion should be considered.

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Psychoses

Anti-psychotic drugs are principally licensed to treat psychoses such as schizophrenia, hypomania and paranoid psychosis. They are also used to treat anxiety and aggressive behaviour. In some circumstances they are used in forensic psychiatry to treat personality disorder.

The original anti-psychotics, also known as neuroleptics and major tranquillisers include chlorpromazine, haloperidol and trifluoperazine. As well as being licensed for the treatment of psychoses they are also licensed for the treatment of anxiety and disturbed behaviour.

The newer atypical anti-psychotics include olanzapine, risperidone and quetiapine. They have a more acceptable side-effect profile with patients than the original drugs with fewer anti-cholinergic and extra-pyramidal side-effects. They may however be more diabetogenic and new evidence is appearing regarding other side-effects. Robust monitoring should be in place for patients receiving antipsychotic medication. They are generally only licensed to treat psychotic conditions however their use in patients suffering from anxiety and personality disorder is increasing. It should be recognised however, that the use of anti-psychotic medication in personality disorder falls outside of NICE guidance.

It is recommended that the use of anti-psychotics should generally be the responsibility of the forensic psychiatrist. Although they may be prescribed by a primary care clinician with suitable training or experience, it is best practice, that in these circumstances, close liaison with a psychiatrist is undertaken and documented.

Anti-psychotics should always be prescribed with caution and only by clinicians competent and experienced in their use. The older drugs have well recognised side-effects including anti-cholinergic symptoms such as dry mouth and constipation and extra-pyramidal problems causing movement disorders such as muscle stiffness and parkinsonism. Neuroleptic malignant syndrome is a rare but serious side-effect.

Atypical anti-psychotics are typically less sedating than the older drugs and cause fewer noticeable side-effects. There is increasing evidence that they can be diabetogenic. Clozapine which is used to treat intractable psychosis can cause significant haematological problems (hence the need for regular blood tests) although the incidence is rare.

Anti-psychotics are the treatment of choice for acutely psychotic prisoners. Each dose should be supervised as they can be dangerous in overdose. The patient's mental state should be carefully assessed and closely monitored. They are not addictive drugs. They are useful in the management of disturbed patients. There are reports of fatal toxicity in high dose long term prescribing of the traditional drugs.

Attention Deficit Hyperactivity Disorder (ADHD)

Continuation of treatment:

ADHD is a persisting disorder. Of the young people with sustained diagnosis, most will go on to have significant difficulties in adulthood, which may include continuing ADHD (NICE 2008). Some adults will therefore arrive in prison with current treatment of this disorder.

This will usually be an amphetamine such as methylphenidate which is the first line of treatment in adults with ADHD (NICE 2008). Amphetamines can be and are abused within prison but in the case of ADHD these prescriptions should be continued without interruption with confirmation from the community prescriber being sought as a matter of urgency, as the trauma of arrest and arrival into custody is likely to have an adverse effect upon this condition. The medication should be continued as it is prescribed in the community initially, until the prisoner has settled and can enter into an informed discussion with regard to any review of treatment that might be indicated if the operational demands of the prison make the previous medication administration times impracticable in the longer term.

Within the prison setting this medication will be given by supervised consumption as it has significant potential to be abused in the prison environment.

Identification and referral of adults with ADHD:

For adults with ADHD drug treatment should be the first line treatment (NICE 2008). Adults presenting with symptoms of ADHD in primary care or general adult psychiatric services who do not have a childhood diagnosis of ADHD should be referred for assessment by a mental health specialist trained in the diagnosis and treatment of ADHD (NICE 2008). It is not appropriate for primary care doctors to make an assumptive diagnosis and initiate a prescription of medication and where that diagnosis is in doubt good practice is the confirmation of the diagnosis. If the diagnosis cannot be confirmed then a psychiatrist should be consulted in the decision to continue or discontinue any medication.

Adults who have previously been treated for ADHD as children or young people and present with symptoms suggestive of continuing ADHD should be referred to general adult psychiatric services for assessment (NICE 2008). In cases where ADHD falls outside of the purview of commissioned forensic in reach services, then individuals should still have access to general psychiatric services and advice should be sought from community services if necessary.

Anti-psychotic medication may be diverted into the illicit economy of prisons. There is evidence that some patients snort or smoke quetiapine for its sedating effects. As such, as stated previously, all of these medicines should be prescribed with caution usually on a supervised consumption basis unless patient compliance and understanding of their condition is very good, and abuse of prescribed medication is not an issue in that particular establishment or on a particular wing, such as a resettlement wing. Here assessment of the patient's ability to manage their own medication will be carried out with checking of concordance with in possession medication, prior to their managing their treatment on release into the community. As a group all of these medications are considered amber. Consideration should always be given to the formulation of the medication chosen with orodispersible and liquid preparations being

effective in reducing diversion potential. Depot medication also provides a method of stopping diversion in patients with chronic psychoses, as well as improving compliance with treatment, and reducing risk in the wider prison population.

Because the reality is that psychiatrists may initiate anti-psychotic medicines but primary care prescribers usually rewrite the prescriptions, it is advisable that there is a written shared care protocol in place to ensure that the metabolic monitoring required for these antipsychotics (as per NICE guidelines) is embedded in the patient's care plan and that the responsibility (primary or secondary care) for undertaking these tests and complying with the monitoring regime is defined. Then both prescribers can be confident in the arrangement and aware of their respective responsibilities.

Medication	Place in therapy	Environmental consideration	Category
Anti psychotic medication	Generally these medications should be initiated by a psychiatrist, but when initiated by a primary care doctor, that doctor should have suitable experience or training and generally they should prescribe within licensed indications.	Clozapine has special monitoring requirements and must be prescribed by a forensic psychiatrist. Registration with the manufacturer's monitoring service is required for the prescriber and the dispensing pharmacy.	

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Clozapine monitoring guidelines
<http://www.mylan-clozapine.com/updatedguidelines.html> [accessed 04 July 2011].

ADHD and Substance Misuse:

Drug treatment for adults with ADHD who also misuse substances should only be prescribed by an appropriately qualified healthcare professional with expertise in managing both ADHD and substance misuse. For adults with ADHD and drug or alcohol addiction disorders there should be close liaison between the professional treating the person's ADHD and an addiction specialist (NICE 2008).

Medication	Place in therapy	Environmental considerations	Category
Methylphenidate	Specialist initiation	Significant abuse potential	
Atomoxetine	Specialist initiation	Significant abuse potential	
Dexamfetamine	Specialist initiation	Significant abuse potential	

Resources

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Benzodiazepines: Use in Anxiety and Other Conditions

Benzodiazepines are highly efficacious in the short term treatment (two weeks or less) of anxiety and insomnia and in managing acute psychosis. When compared to their predecessors the barbiturates, they have an improved safety profile as they have a wider therapeutic window. They are drugs of very high abuse potential and as a class of medication they have significant potential to induce dependency. Unfortunately some patients quickly become dependent upon benzodiazepines and experience uncomfortable physical and psychological withdrawal symptoms. The physical syndrome associated with withdrawal from long term benzodiazepine use may include depression, anxiety, psychosis, suicide, status epilepticus and may be fatal. For these reasons it is generally not acceptable to initiate treatment with benzodiazepines in patients and treat them for longer than two weeks.

Many patients became dependent upon these drugs in the community in the three decades following their introduction in the 1960s before evidence emerged of their addictiveness and clinicians changed their prescribing practice. Many patients remain dependent upon them. Encouraging patients to stop taking them is difficult but remains appropriate. Slow reduction (over weeks and months) remains the treatment plan of choice in individuals without a severe current mental illness. Where a severe mental illness is present reduction may still be appropriate but should only be undertaken after liaison with a psychiatrist.

Benzodiazepines are very popular among drug users. They are widely available in the community as they are widely prescribed and thus easily diverted for illicit use. They are also easily purchased via the internet. They are sedating drugs which give an initial euphoria followed by relaxation and sleep. They can synergise the effects of heroin, other opiates including methadone, and alcohol. When combined in a cocktail with other substances they have been implicated in fatal accidental overdose. Drug users typically take them in large quantities orally for their euphoric effect and it is not unusual for doses of 100mg of diazepam to be reportedly consumed on a daily basis. Historically they have been injected however this method of administration is believed to be less prevalent at present. Their availability illicitly in prison is less than in the community but they remain highly sought after within secure environments. As a result, the prison clinician is frequently asked to prescribe medication for reported anxiety and they should be constantly vigilant to the possibility of this presentation being a route to inappropriate benzodiazepine use.

Diazepam is commonly used by Forensic Medical Examiners (FMEs) to alleviate the agitation associated with heroin withdrawal in Police custody and for treatment of anxiety: a positive urine test for benzodiazepines for patients received from police custody should not be used as the sole indicator of dependency. Benzodiazepine dependent patients entering custody whose dependency is proven or suspected and supported by urine testing should be treated in accordance with guidelines by slow reduction¹. Treatment of benzodiazepine dependent patients whose dependency has been established and where diversion is a risk should be with diazepam liquid. Dependency may not be present where patients use benzodiazepines intermittently or irregularly.

Chlordiazepoxide is used to treat alcohol withdrawal. When an alcohol dependent patient enters custody they should be treated with a chlordiazepoxide detoxification regime over a suitable time period which is typically around one week for low dependence. Dose regimes and length of treatment are dependent on the assessment of dependency and monitoring of withdrawal in line with locally agreed evidence based protocols. Patients in treatment are still at risk of fitting and should be closely monitored.

All general practitioners including GPs who work in prisons should generally avoid prescribing benzodiazepines other than in special circumstances. They should not use them to treat insomnia. Occasional prescribing for debilitating anxiety or spasmodic back pain is recognised however within prisons it should be considered best practice to explore other treatments where appropriate first. An example of this would be the prescription of buspirone to treat anxiety that has not responded to a cognitive behavioural therapeutic approach.

Benzodiazepines may be used in the very short term to treat acute distress from bereavement and in psychosis, though treatment with anti psychotic medication is preferred in psychotic patients.

There is no indication for prescribing lorazepam on an ongoing basis. It is the most addictive benzodiazepine.

Clonazepam treatment is often requested by prisoners on the grounds that they have epilepsy for which it is a licensed adjuvant treatment (see section on epilepsy earlier in this guidance). It is however popular in non-epileptic patients who take it as a hypnotic and misuse it. It is crucial therefore that the prison General Practitioner confirms the diagnosis of epilepsy and its treatment with clonazepam prior to prescribing as misuse and inappropriate prescribing demands are well recognised within the prison population.

General Practitioners have a responsibility to limit benzodiazepine prescribing and reduce diversion and misuse. This is especially important in prisons where drug users will actively seek benzodiazepines for their euphoric, anxiolytic and hypnotic effect. They may be used as currency within the illicit economy of a prison and their presence in the illicit economy does lead to bullying and violence.

When a clinician considers it appropriate to prescribe a benzodiazepine, they should be aware of the potential for paradoxical or disinhibitory reactions. These may include acute excitement, hyperactivity, increased anxiety, hostility and sometimes rage. In high risk patients these paradoxical reactions may be in the region of 10 – 20% of patients. Those considered high risk of paradoxical reaction include patients with learning disorders, young patients and those individuals who have a history of aggression and poor impulse control.

Benzodiazepine use should usually be restricted to benzodiazepine and alcohol dependent patients treated under clear guidelines. They may also be used in florid psychosis when a forensic psychiatrist should be involved with treatment, some cases of epilepsy including the acute management of status epilepticus with rectal diazepam and end of life care (midazolam).

Although not a benzodiazepine, buspirone may play a useful role in the management of anxiety. It displays less dependency potential than benzodiazepines. It should not be used for benzodiazepine withdrawal, but offers an appropriate method of augmenting the action of antidepressants and may be used appropriately by primary care doctors in this role. Propranolol also has a role in the treatment of anxiety within prisons. It is not subject to misuse and can be prescribed to reduce some of the physical symptoms of anxiety. It may therefore be considered to have a benzodiazepine sparing effect.

Medication	Place in therapy	Environmental consideration	Category
Diazepam	Usually in the form of a detoxification regime but exceptions do occur.	In patients with proven or suspect history of illicit use, diazepam should be prescribed as a liquid formulation where diversion is a risk.	
Chlordiazepoxide	Alcohol detoxification.		
Lorazepam	Rapid sedation in distressing anxiety.	Short term use only (not to be used for maintenance).	
Midazolam	Terminal care.	As an unlicensed medication buccal Midazolam may be used to treat an epileptic seizure. Clinicians should be aware of the ease of faking a seizure as a route to getting benzodiazepines administered.	
Clonazepam	Adjunct in epilepsy.	Confirmation of prescription and diagnosis should be sought. Sought after for its abuse potential.	
Benzodiazepines	insomnia.		

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Insomnia

Introduction:

Sleep problems are regularly presented to prison healthcare staff. The prevalence of substance misuse and alcohol dependency combined with the loss of autonomy and sedentary lifestyle in prison make this understandable.

Drug misusers have a tendency to seek pharmacological remedies rather than psychosocial ones for insomnia. It can be difficult to dissuade them from this approach. NICE guidance states:

“When, after due consideration of the use of nonpharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, it is recommended that hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications.” (NICE 2004)¹.

NICE recommends not substituting one drug for another if the first line drug is ineffective. Whilst short acting benzodiazepines are recommended as being most cost effective, these drugs are widely abused in prison settings and routine use is discouraged.

One of the problems a clinician who works within prisons will experience when assessing insomnia is the expectations of the individual who has a history of drug and alcohol misuse. Sleep patterns may be acceptably normal from a clinical perspective but from the patient perspective, sleep latency and normal disruption of sleep is contrasting to their usual experience of sleep induced by illicit benzodiazepine use, heroin use and alcohol use. Education and the offering of realistic expectations can help in this scenario.

Patients within prisons do have justifiable requests for hypnotic medication though and not all requests for hypnotics are inappropriate. Significant life stresses may impact on sleep and this may affect daytime functioning. Before a court appearance or on receipt of a long sentence may both be justifiable scenarios in which a clinician could offer night sedation. In these circumstances there may be a reduction in the risk of deliberate self harm. Bereavement and the stress of release after a protracted period in custody could also justify prescribing a hypnotic. It is less justifiable to prescribe hypnotics for chronic insomnia and routinely for withdrawal symptomology during detoxification from illicit drug misuse although at the end of a reduction regime this may occasionally be justified for a very short period as the patient adjusts to the first few days of abstinence. Patients receiving treatment for Hepatitis C are often prescribed a short course of a hypnotic such as zopiclone for use around the time of their peg-interferon injection to assist in the treatment of insomnia.

Milky drinks may have a place in the management of sleep problems and are recommended as part of the Integrated Drug Treatment System clinical guidelines (DH 2006) for the first fourteen days of treatment. Prisons have offered this as part of a reduction in the routine prescribing of hypnotics for withdrawal management since 2000 and generally report this intervention to have a positive effect and to be well received by the prisoners.

The provision of lavender oil has also been used to good effect in some centres in the female estate.

A sleep diary may be requested from the patient. It is also possible within some prison settings for this reported sleep pattern to be confirmed with observation of the patient’s sleep pattern by prison night staff.

Sleep hygiene should be discussed when a patient presents with uncomplicated insomnia. Although not fully transferable in practice to the prison setting, sleep hygiene recommendations still have a role and the effect of reducing caffeine intake, not exercising late at night etc., may be helpful.

The NHS Choices patient leaflet may be offered to inform the patient about the reasons for prescribing or not. It is also appropriate to adapt this leaflet to reflect the prevalence of learning difficulty within patients held within the prison estate.

Sedating antihistamines, benzodiazepines, Z drugs and melatonin are licensed for the short term management of insomnia.

One melatonin product is currently licensed for short term use in insomnia for patients over 55 years of age. It is not widely used within prisons and because of this limited use there are currently no reports of misuse. If used routinely within a particular establishment, then misuse may follow and clinicians should be aware of this. As a recently licensed product, many local health communities will restrict the preparation to prescribing by consultants in secondary care and this should be taken into account as part of the prescribing decision process.

Recommended drugs:

Drug	Dose	Prescribing notes and environmental considerations	Category
Melatonin		Limited licence. Not known to be widely misused – See notes above.	
Z drugs: Zopiclone, Zolpidem and Zaleplon		These can be used for short periods if there is a clear necessity for a hypnotic. Zopiclone is the most widely used in the community. They may be diverted and do enter the illicit economy. Prescribe with caution in prisons.	
Promethazine	25-50mg	Traditionally used as a ‘safer’ hypnotic in prisons but widely abused in the community. Misusers report that anticholinergic antihistamines are used to boost opiate highs. Sedation lasts up to 12 hours so likely hangover effect next morning with psychomotor impairment. Hypnotic effect wears off after a few days.	
Temazepam	10-20mg	Generally the use of benzodiazepines remains discouraged within a prison environment. Temazepam and other benzodiazepines should not be chosen on cost grounds alone. The choice of a benzodiazepine should be justified within the clinical notes and the time limited treatment plan should also be documented.	

References:

NICE. Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia. Paragraph 1.1. Technology Appraisal 77. London: NICE, 2004.
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Joint Formulary Committee. British National Formulary. 60 ed. London: British Medical Association and Royal Pharmaceutical Society of Great Britain; 2010.
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Substance Misuse

Clinical treatment of Substance Misuse in prisons is detailed in *Clinical Management of Drug Dependence in the Adult Prison Setting* (DH 2006).

One of the main difficulties facing clinicians practising within a custodial setting is the potential for misuse of many of the medications prescribed for the management of substance misuse. None of these drugs can be given *In Possession* (PSO 3550 – Clinical Services for Substance Misusers and PSI 45/2010 Integrated Drug Treatment System), and the timing of the administration of some of these drugs may need to be considered taking into account the operational demands of the prison, although there is a need to ensure that the treatment needs themselves are not compromised.

Methadone is recommended as first-line treatment in prisons for the treatment of opiate substance misuse in line with the evidence base and guidance (DH 2006; NICE 2007). Buprenorphine is a treatment option for some patients particularly those who come into prison already on an existing community prescription.

The perceived advantages of prescribing Suboxone over buprenorphine are mainly in community models to prevent misuse or accidental overdose in those patients who do not have supervised consumption models of care, to prevent harm from injecting or snorting buprenorphine or accidental overdose by another person. In prison all administration is by supervised consumption, so there is no clinical rationale for using Suboxone over plain buprenorphine. There are no Royal Pharmaceutical Society guidelines/advice for crushing Suboxone as there is for buprenorphine. The authors are unaware of any studies investigating the possible loss of efficacy of Suboxone by crushing which have vindicated this method of administration.

In addition to the clinical matters above, the practicalities in a prison are such that there is not the time to safely administer Suboxone to a large number of patients by supervised consumption. Any such administration by crushing would therefore not only be 'off licence' but could also impact on healthcare professionals' indemnity insurance and lead to the possibility of exposure of litigation with regard to efficacy. Buprenorphine misuse is widespread, both in the community and in prisons. Misuse has been found to be prevalent in prisons where it is not prescribed, as it comes into prison via the usual illicit supply chains. Changing to Suboxone rather than Buprenorphine is not likely to reduce illicit use within the prison.

In all cases of prescribing for opiate substitution, the dialogue is with the prescriber and patient as to the best clinical treatment within the current treatment guidelines and protocols, and the prescriber should be aware of all of the pressures to prescribe particular drugs.

Where prisoners are received into prison already stabilised on a treatment regime initiated in the community then it is good practice to maintain that treatment regime for remand prisoners or those with a short sentence (in accordance with National Treatment Agency guidelines).

Opiate substitute prescribing forms a large part of the treatment for substance misusers in prison. Whilst there needs to be an equivalence of treatment options comparable to the community, it is also important to acknowledge that illicit drugs may be less readily available in a prison environment and that this should be taken into account when making clinical decisions about the prescribing of substitute medication for opiate users in prison.

Doctors working in prisons should also be aware of the demand for codeine based analgesics including tramadol within a prison as described within the previous sections above. They should ensure that these are not prescribed to maintain a substance misuse habit and that where necessary the patient is assessed for an opiate dependency if this is suspected. Opiates are generally unsuitable for use

in patients with a history of substance misuse for the treatment of mild to moderate pain. It is vital that the fact that the patient is being treated for, or has a history of opiate dependence, should be made known to all other prescribers, including dentists so that appropriate pain management may be used.

References:

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Resources:

NICE. Methadone and buprenorphine for managing opioid dependence. NICE technology appraisal guidance 114. London: NICE, 2007.
<http://www.nice.org.uk/nicemedia/live/11606/33833/33833.pdf> [accessed 04 July 2011].

NICE. Naltrexone for managing opioid dependence. NICE technology appraisal guidance 115. London: NICE, 2007.
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Palliative Care

GPs play an important part in managing patients in a palliative care context. An ageing prison population necessitates the increasing application of these skills to the prison setting. Strong opiate medication is often used in palliative care patients with cancer.

Injectable opiates and midazolam are useful medicines for patients in the terminal stage of their illness. Prison health care teams should have guidelines in place for the safe and compassionate treatment of patients who need end of life care. The team should be aware of and deploy the Gold Standards Framework and Liverpool Care Pathway when appropriate. The security implications of administering powerful opiates and benzodiazepines in the prison must be carefully evaluated.

Reference:

Department of Health. End of Life Care Strategy: quality markers and measures for end of life care. London: Department of Health, 2009.
<http://www.londonhpa.nhs.uk/wp-content/uploads/2011/03/DH-EOLC-strategy.pdf> [accessed 04 July 2011].



Notes

Safer Prescribing in Prisons