An audit of medication prescribing practices following imprisonment

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Authors

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Executive Summary

Introduction

UK policy entitles prisoners to the same standard of healthcare as that available in the wider community, including pharmacy services (DH, 2003). Although approximately £7 million is spent annually on medication in prisons across England and Wales (DH, 2003), there is limited information available on prescribing. However, there is evidence to suggest there may be a lack of continuity in prescribing between prison and community settings; one study found that two thirds of prisoners received into custody with current prescriptions of psychotropic medication did not receive that medication during their first month in custody (Shaw et al, 2006).

Aims

This audit aimed to measure the extent to which standards relating to prescribing medication for newly received prisoners were being met in a sample of English prisons. The following three standards, adapted from the available literature, were used.

1. Contact should be made with the community prescriber: on the day of reception/the next day for those receiving prescribed medication for substance dependence, or within a month for those on all other medications.
2. A decision regarding the prescription of medication in prison should be recorded in the prisoner’s clinical record.
3. Prisoners with mental disorders should continue to receive their prescribed medication in prison, unless and until deemed unnecessary as a result of psychiatric assessment.

Methods

The fieldwork took place in five local prisons in the North of England between June 2008 and February 2009. A ‘census month’ was chosen at each prison and clinical records for all people newly received into custody within this month (excluding prisoners transferred from other establishments) were gathered. In total, 1006 (95%) of the 1058 records eligible for inclusion were successfully reviewed as part of the audit.

Where a newly received prisoner reported being in receipt of prescribed medication in the community, this was deemed to be an ‘audit case’. For each audit case, an audit form was completed to determine whether each audit standard had been met. This included details of pre-custody medication, contact with community prescribers to verify prescriptions and whether or not prescriptions were continued in custody.
Results

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percentage of cases where standard was met</th>
</tr>
</thead>
</table>
| 1        | Contact should be made with the community prescriber: on the day of reception/the next day for those receiving prescribed medication for substance dependence, or within a month for those on all other medications. | Substance dependence: 33%  
All other: 41%  
(Tables 4 & 5) |
| 2        | A decision regarding the prescription of medication in prison should be recorded in the prisoner’s clinical record. | 91%  
(Table 6) |
| 3        | Those prisoners with mental disorders should continue to receive their prescribed medication in prison, unless and until deemed unnecessary as a result of psychiatric assessment. | 64%  
(Table 7) |

Recommendations

1. Where a newly received prisoner reports currently being in receipt of prescribed medication prior to custody, prisons should contact the relevant prescriber to verify prescription claims. This should happen in every case, unless the prisoner is well known to services or reliable alternative evidence is available (e.g. the prisoner is in possession of a valid copy of their current prescription).

2. We recommend that prisons should aim to verify prescriptions for newly received prisoners by the end of the working day following reception into custody. This target should be communicated to staff, included within written training materials, policies and procedures, and be subject to routine audit.

3. Responsibility for verifying the prescriptions of newly received prisoners should be delegated to a named person, or persons. This person should also have responsibility for communicating the findings of any enquiries back to the prison GP (or other named prescriber). The results of any enquiries made should be recorded clearly in the notes.

4. Where prison staff are not able to locate community prescribers or obtain verification within this time, the prisoner should be re-assessed in custody by an appropriate qualified individual in order to determine whether or not a new prescription should be issued. The results of this assessment should be recorded clearly in the notes.

5. Prisoners with prescriptions for medication for mental health problems, verified by community prescribers, should continue to receive their prescribed medication in prison, unless and until deemed unnecessary as a result of psychiatric, or other appropriate assessment.

6. Healthcare teams should consider the range of ways that prisoners can make contact with them regarding medication queries (e.g. applications, via telephone).
The ways in which prisoners can contact healthcare should be clearly described in any literature on healthcare services given to newly received prisoners.

7. Prisons with, or planning to use, electronic clinical records systems should consider what clinical information is recorded and stored in paper form, and how this can be made accessible to the full range of healthcare staff that require access, including upon transfer/discharge.
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1 Literature review

1.1 Introduction

The prevalence of physical and mental health disorder is higher in prisons than in community populations. Indeed, it has been estimated that ninety percent of prisoners have a mental illness, substance misuse problem or both (Singleton et al, 1998). Offenders often come from deprived backgrounds, leading chaotic lifestyles outside of prison with little contact with healthcare services. Coming into custody can therefore present a valuable opportunity for health professionals to re-engage with this so-called ‘hard to reach’ group to improve their health and life chances.

In the past prison healthcare was delivered by HM Prison Service. However the range, quality and consistency of services across the estate were often criticised. In 1997 the Health Advisory Committee (HAC) for the Prison Service concluded that prisoners should have access to ‘the same quality and range of health care services as the general public receives from the NHS’ (HAC, 1997). A joint NHS/Prison Service working group was convened to consider the possibility of transferring responsibility for providing healthcare in prison from the Prison Service to the NHS and their recommendations were presented in The Future Organisation of Prison Healthcare (1999). Their recommended programme of changes to work towards this goal was accepted in 1999 and a formal partnership between the NHS and the Prison Service was formalised in 2000. In April 2006, responsibility for funding and delivering prison healthcare completed its transfer to the NHS.

Medication is a cornerstone of modern healthcare. UK policy entitles prisoners to the same standard of healthcare as that available in the community, including pharmacy services (DH, 2003). Although approximately £7million is spent annually on medication in prisons across England and Wales (DH, 2003), the prescribing data available is limited. However, there is evidence to suggest there may be a lack of continuity in prescribing practices between prison and community settings. Indeed, one study found that two thirds of prisoners received into custody with current prescriptions of psychotropic medication did not receive that medication during their first month in custody (Shaw et al, 2006).

This audit aimed to measure the extent to which standards drawn from the good practice literature relating to prescribing medication for newly received prisoners were being met in a sample of English prisons. The following literature review aims to contextualise this report by firstly, describing the health needs of the prison population; secondly, identifying the key issues facing prescribers working in prison environments; and thirdly, reviewing the relevant research literature in relation to prescribing.
1.2 Physical and mental health disorder in prison populations

Prison populations exhibit different patterns of physical and mental disorder than community populations. Newly received prisoners are more likely than community populations to report engaging in risky activities such as drug and alcohol misuse (Fazel et al, 2006; Jones & Hoffman, 2006), tobacco use (Lester et al, 2003) and unprotected sex (Plugge et al, 2006). Physical health is comparatively poorer in prison populations with higher rates of communicable diseases such as hepatitis B and C, tuberculosis and HIV (Long et al, 2001; Weild et al, 2000; Butler et al, 2007; Thompson et al, 2008). A large-scale UK study has also reported higher rates of chronic diseases amongst prisoners when compared to the wider community; 46% of their sample of sentenced males had some form of longstanding illness or disability such as heart disease, asthma and diabetes (Bridgwood & Malbon, 1995). Evidence suggests that particular groups such as women, young offenders and older offenders have distinct physical health needs (Howse, 2003; Plugge, Douglas & Fitzpatrick, 2006; Harris et al, 2007). For example, older prisoners may require specific services for age-related disability and disease (e.g. arthritis, hearing impairment) as well as physical concessions (e.g. lower bunks, ground floor cells).

Rates of psychiatric disorder are also high in prisons. One large study by the Office for National Statistics (ONS) reported that 90% of prisoners had a diagnosable mental illness, personality disorder and/or a substance misuse disorder (Singleton et al, 1998). The study estimated that 9% of men and 21% of women on remand had probable psychosis, whilst 17% of men and 21% of women remand prisoners had major depressive disorder. With regard to substance misuse, the same study found that over half of prisoners entering custody had been dependent on alcohol or drugs (opioids, stimulants and/or cannabis) in the year prior to imprisonment.

Prisons contain, therefore, populations with a high prevalence of physical and mental illness. Such problems are often further complicated by poly-substance misuse and co-morbidity. Although offenders are often viewed as a difficult group to engage with outside of custody, in prison they have been shown to have high rates of contact with primary care health services (Marshall et al, 2001). Thus, a period in custody may potentially provide an opportunity for health professionals to detect, diagnose and treat identified health problems (Reed & Lyne, 2000). This may involve contact with relevant primary and secondary care health services and/or the use of prescribed medication.

1.3 Prescribing in a secure setting

The prescription of medication can have an impact not only on individual patients but on the prison regime as a whole: provision of appropriate medication can help to reduce violence and aggression, reduce illicit drug taking in prison and
ameliorate symptoms sufficiently to enable individuals to participate in purposeful activity (DH, 2003; Dolan et al, 2003). UK policy entitles prisoners to the same standard of healthcare as that available in the community, what is known as the principle of ‘equivalence of care’ (Wilson, 2004). Equivalence, however, may not necessarily mean identical. In practice a number of factors affect the prescription of medication in secure settings such as prisons. Prescribing practices in prisons therefore may differ from those found in the community, both in terms of the decision making processes surrounding prescribing and with respect to the particular types and forms of medications that are prescribed as a result.

Prisons can be harsh environments where distress, boredom and bullying are commonplace (Nurse et al, 2003). Drug misuse is not unusual in prison (Boys et al, 2002), and rates of suicide and self harm are high (Fazel et al, 2004). When making clinical decisions, prescribers working in prisons must balance security needs with the patient’s clinical needs, giving due consideration to the risk that medication could be diverted or misused. Certain medications are particularly susceptible to illicit use and can become ‘currency’ in prisons; opioids, benzodiazepines, sedatives and salbutamol inhalers have all been identified as potentially risky prescription choices (Wayman, 2006).

A range of measures are routinely used in prisons in order to reduce the potential risks associated with prescribing and issuing medication. These include measures relating to the types of medication prescribed, such as substituting certain medications with safer alternatives or prescribing alternative formulations (e.g. liquids) that are more difficult to divert or misuse. For example, when compared to older tricyclic antidepressants, newer SSRI (Selective Serotonin Reuptake Inhibitor) antidepressants offer improved safety in the event of overdose (NICE, 2007). Other strategies relate to controlling the way medication is stored and administered. Prisons may, for example, make certain medications (e.g. methadone) available only if consumed under the supervision of prison staff, rather than being held ‘in possession’ by the patient. Such considerations, in combination with the complex health needs that offender populations present with, mean that the resultant patterns of prescribing in prisons may reasonably and understandably differ from those found in the wider community.

1.4 Trends in prison prescribing

Unlike in the community, where regular reports on prescribing patterns are made available to prescribers, prescribing data in UK prisons are variable in quality and difficult to collate (DH, 2003). Thus, there is a lack of information on prison prescribing patterns across the estate in general. The limited data available suggest that prisoners appear more likely to be in receipt of prescribed medication than community patients. An ONS study found that about a fifth of men and half of women prisoners were in receipt of some sort of medication acting on the central nervous system (Singleton et al, 1998). The equivalent rates of prescribed medication use in the general UK population appear to be much lower; Ohayon et
al (1998) reported comparable prescribing rates of 2% amongst men and 5% amongst women.

There is some evidence to suggest that prescribing trends may vary between establishments. Wiffen (cited in DH, 2003) conducted a small-scale survey on prescribing and associated expenditure using data from five English prisons. This showed variation between prisons in both the types of medication prescribed and average prescription costs. Notably, average annual costs per prisoner were highest at the local remand and high secure establishments (£273 and £167 respectively); the average cost per head in both of these establishments exceeded that for prescriptions in the English general population as a whole (£110). Such findings may reflect differences in the health needs of the populations served, in the prescribing policies used by individual establishments, or indeed both. A recent evaluation of in-possession medication procedures in prisons found that establishments varied in terms of the policies and risk assessments used when prescribing (Shaw et al, 2009).

1.5 Prescribing for newly received prisoners

One of the key opportunities for health needs, including medication needs, to be identified in prison is upon reception into custody. Reception health screening is widely regarded as a key stage in identifying physical and mental health needs, and determining the care that a prisoner will subsequently receive (HMPS, 2004; Birmingham, 2001; Birmingham, Gray, Mason, & Grubin, 2000). One survey found that 34% of men entering UK prisons reported being on some type of prescribed medication prior to custody (HMIP, 2000). Studies in female populations have reported even higher rates of 53% (HMIP, 2000) and 73% (Plugge, Douglas & Fitzpatrick, 2006).

The initial period of custody offers an opportunity to examine continuity and equivalence of care between prison and community settings. Using prisoner clinical records, Shaw et al (2006) tracked the care of a sample of over 2000 prisoners across five UK prisons from reception into custody until discharge. They found that, amongst those prisoners received into custody reporting a current prescription for psychotropic medication, 64% did not receive that medication during their first month in custody. Furthermore, interviews with prisoners as part of the same study indicated that discontinuation of pre-prison medication caused significant distress at an already stressful time (Bowen et al, 2009). These findings are consistent with those reported by Plugge et al (2008) who used focus groups to explore the attitudes of female prisoners in southern England towards prison primary care services. Plugge et al reported that women complained of medication being withheld on entering prison, particularly antidepressant and sleeping medication, with no clear reasons apparently given for their discontinuation.

As Shaw et al (2006) acknowledged, it is not yet clear whether pre-custody medication is discontinued through a process of omission rather than as a result of active decision making. Indeed, prisoners’ medication claims may not always be
checked with community prescribers. A recent survey of local prisons found that whilst 78% stated that they aimed to verify the prescriptions of newly received prisoners within three days of reception into custody, less than half of establishments had included this in a written policy (Shaw et al, 2009). Alternatively, it could be that pre-custody medications are being deemed unnecessary as a result of a clinical assessment once in custody. The same survey reported that 76% of prisons said they reviewed the medication needs of all newly received prisoners in receipt of prescribed medication prior to custody (Shaw et al, 2009). Such issues require further attention to establish the true reasons for discontinuation.

1.6 Summary

UK policy entitles prisoners to the same standard of healthcare as that available in the community, including pharmacy services (DH, 2003). The available evidence suggests, however, that prescribing practices in prisons may differ from those found in the community, both in terms of the decision making processes surrounding prescribing and with respect to the particular types and forms of medications that are prescribed as a result.

The initial period following reception into custody provides a useful opportunity to compare prescribing between prison and community settings. A study by Shaw et al (2006) found that 64% of prisoners received into custody with current prescriptions of psychotropic medication claimed they did not receive that medication during their first month in custody. However, it is not clear from such work whether prisoners were not prescribed medication because: (a) following investigation and clarification from outside services it transpired that they were not on that medication; (b) clinical assessment in prison deemed the medication inappropriate; or (c) medication was discontinued through a process of omission rather than as a result of active decision making. An audit of practice was proposed in order to clarify these findings.
2 Method

This section describes how audit standards were selected and developed. It then describes the sample of establishments that participated in the audit, and procedures used to collect and analyse data.

2.1 Selection and development of audit standards

A range of prison healthcare policy documents were reviewed to identify references relating to arranging care for those received into custody with current prescriptions. A decision was made to be broad in scope and to consider the full range of prescribed medications rather than only psychotropic medications in order to provide comparative data. A series of auditable standards were adapted from the literature, described and justified below.

Standard 1: Contact should be made with the community prescriber: on the day of reception/the next day for those receiving prescribed medication for substance dependence, or within a month for those on all other medications.

Evidence: Prison Service Order (PSO) 0500 (Reception) states that ‘an assessment of the healthcare needs of every prisoner must be undertaken on Reception... to identify existing health problems and to plan any subsequent care’ (p.20). As part of this assessment, PSO 3050 (Continuity of Healthcare for Prisoners) states that on reception into custody ‘efforts should be made to retrieve any information required from the prisoner’s GP or other relevant service he/she has recently been in contact with’ (HMPS, 2006 p.4). While there is no specific guidance in relation to the timing of this contact, we decided that a maximum time limit of one month would be suitably generous. DH guidance on the clinical management of drug dependence recognises the need for contact with community prescribers. This is most specific with regard to those receiving prescriptions for methadone, stating that on the day following reception ‘confirmation needs to be obtained from the prescribing doctor/drug service of the dose and duration of methadone treatment’ (DH, 2006 p.22). Therefore a stricter time limit of one day after reception into custody (same day/next day) was adopted for those prisoners who reported being prescribed medication for opioid dependence\(^1\) in the community.

\(^1\) Although much of the DH guidance in the policy document (DH, 2006) refers specifically to methadone, it is recognised within it that that other treatments, in particular buprenorphine, are acceptable for treating opioid dependence. Thus, for the purposes of this audit the standard was extended to all opioid medications accordingly.
**Evidence:** In the NHS, medical records are primarily used to record and communicate decisions about patients and their healthcare (Academy of Medical Royal Colleges, 2008a). High quality record keeping is essential in order to facilitate continuity of care and avoid confusion, frustration and litigation. The General Medical Council (GMC) defines standards for good record keeping practices which apply to all registered doctors. These include the requirement to ‘keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment’ (GMC, 2006, p. 8). Usefully, the Royal College of Physicians, in partnership with NHS Connecting for Health, has recently developed a guide on record keeping standards (Academy of Medical Royal Colleges, 2008b). Although intended for hospital doctors, this identifies a number of suggested headings and subheadings for structuring entries that could reasonably be applied within prison settings including GP details, admission details, patient details, outstanding issues and clinical information. Within the latter section, specific reference is made to ‘medication recommendations’ (ibid, p. 8):

‘A medication recommendation about a drug or device allows a suggestion to be made for starting, discontinuing, changing or avoiding items in a patient’s medication record. The medication recommendation may be made to another clinician or directly to the patient. Examples include:

- continue medication x and y
- change dose of z after 3 weeks
- consider change from medication a to med b if not effective
- stop medication c and d.’

For the purposes of this audit, either a prescription or any specific reference relating to the continuation or discontinuation of medication (in the notes), whether or not dependent on outstanding investigations or tasks (including GP confirmation) was regarded as sufficient evidence to meet this standard. Again, in the absence of any specific guidance in relation to the timing of this contact, following discussions with the supervision team a maximum time limit of one month was seen to be suitably lenient.

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2 Examples of acceptable statements include the following: ‘medication to be prescribed in line with GP meds’, ‘contact GP to confirm’ or ‘to check with GP’. However, it excludes cases where medications had been verified by the GP correct, but were not subsequently prescribed in prison without a documented reason for this (e.g. prescription of a substitute medication).
Evidence: Changing the Outlook (DH, 2001) identifies the need to ensure continuity of care for those with mental health needs, with specific reference to medication:

‘No one who has been in receipt of medication for a mental disorder should have it automatically withdrawn on entry into prison unless and until a proper psychiatric assessment has indicated that this is appropriate.’ (p.21)

For the purposes of this audit, medications falling into the following BNF classes were deemed to be medications for mental health disorder: antidepressants, antipsychotics and hypnotics/anxiolytics.

In order to accurately measure practice against the standard, a period of one week from reception into custody was defined for a decision regarding medication to be made. This cut-off time was chosen following discussions within the audit team. A week was seen to be the longest reasonable period within which busy local prisons (which often receive high volumes of prisoners late into the evening) could confirm prescriptions, without neglecting the immediate health needs of the patient. We decided to exclude from this analysis all cases where, within the first week of custody, the community prescriber confirmed that there was no current, valid prescription for the medication. In all remaining cases where a prisoner reported being in receipt of prescribed medication for mental health disorder, the standard was met if:

- the medication was prescribed in the first week of custody, whether or not the community prescriber was contacted; or
- the medication was not prescribed in the first week of custody, but there was evidence of a formal psychiatric assessment within the first week of custody.

A psychiatric assessment was deemed to include any mental health assessment with a suitably qualified member of staff\(^3\).

\(^3\) This included psychiatrists, psychologists, CPNs, RMNs, dual diagnosis specialists or other suitably trained mental health professionals. This did not include GP consultations.
2.2 Sample

The fieldwork took place between June 2008 and February 2009 in five local prisons (which remain anonymous for the purpose of this report), all of which accepted prisoners directly from court. All prisons were located in North West or North East England. Sites were selected for inclusion in the audit with the aim of reflecting a range of prison populations including adult male, young male, adult female and young female prisoners. Participation in the audit was voluntary. Relevant audit approvals were obtained from prison Governors and the relevant NHS Primary Care Trusts providing care at each prison.

At each prison, a month of records were sampled for the audit. A ‘census month’ was chosen at each prison and clinical records for all new receptions into custody within this month (excluding prisoners transferred from other establishments) were deemed eligible for inclusion in the audit. Table 1 provides brief details of each site, the number of records eligible for inclusion within the selected census month and the number of these records successfully reviewed.

Table 1: Sample

<table>
<thead>
<tr>
<th>Prison</th>
<th>Type</th>
<th>Census month</th>
<th>Total new receptions in census month</th>
<th>Records reviewed (% of total new receptions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Adult male local</td>
<td>August 2008</td>
<td>262</td>
<td>99% (260)</td>
</tr>
<tr>
<td>B</td>
<td>Adult male local</td>
<td>June 2008</td>
<td>302</td>
<td>99% (298)</td>
</tr>
<tr>
<td>C</td>
<td>Adult and young female</td>
<td>August 2008</td>
<td>68</td>
<td>97% (66)</td>
</tr>
<tr>
<td>D</td>
<td>Adult male local + high secure function</td>
<td>July 2008</td>
<td>296</td>
<td>100% (296)</td>
</tr>
<tr>
<td>E</td>
<td>Youth offender institution</td>
<td>February 2008</td>
<td>130</td>
<td>66% (86)</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td></td>
<td>1058</td>
<td>(95%) 1006</td>
</tr>
</tbody>
</table>

Overall, 95% of records eligible for inclusion in the audit were successfully reviewed. Notably, the proportion of records successfully reviewed was lowest (66%) at Prison E, the Youth Offender Institution (YOI). This was because the prison had not yet installed an electronic clinical records system and were reliant on paper records. The vast majority (77%) of the records that could not be located were those of prisoners that had been transferred elsewhere, with their records travelling with them.
2.3 Procedure

For each new reception into custody during the census month, reception health screening records were checked to determine whether or not the prisoner reported being in receipt of prescribed medication\(^4\) in the community immediately prior to custody. If the prisoner did not report being in receipt of prescribed medication in the community, no further action was taken. Each instance where the prisoner reported being in receipt of prescribed medication was deemed an ‘audit case’ and allocated an anonymous audit ID number. For each audit case, an audit form (Appendix 1) was completed. This established the following information in each case in order to determine whether the audit standards were met:

a) Details of all pre-custody medication, as reported by the prisoner (drug name, dosage).

b) Whether or not prison healthcare staff made initial contact with the community prescriber to confirm or refute prisoners’ medication claims; on the same day as, or the day after reception into custody for drugs for substance dependence; or within 1 month for all other medications.

c) Whether or not medication, or an appropriate substitute, was prescribed in custody and when.

d) Whether or not a formal decision regarding the future prescription or discontinuation of medication in prison was documented in the prisoner’s clinical record.

e) For prisoners claiming to be in receipt of medications for mental health problems, whether or not a psychiatric assessment took place within a month of reception into custody.

2.4 Analysis

Data were inputted into SPSS version 15 (SPSS Inc., 2006). Descriptive statistics were used to describe the proportions of newly received prisoners that reported being in receipt of different types of medication. Individual medications were categorised in line with their classifications as listed within the British National Formulary (BNF) 56 (BNF, 2008). This included antidepressants, antipsychotics, hypnotics/anxiolytics, medication for substance dependence and medication for physical disorders (including asthma, epilepsy and diabetes). A list of the classifications used and the most common medications within each can be found in Appendix 2.

Descriptive statistics were then used to determine the proportions of cases in which audit standards were met.

\(^4\) Excluding over-the-counter medications e.g. paracetamol.
3 Results

3.1 Prevalence of reported medication use prior to custody amongst new receptions into custody

Table 2 details the types of medication newly received prisoners reported being prescribed in the community, immediately prior to reception into custody.

Table 2: Prevalence (%) of reported current prescribed medication use amongst new receptions into custody by BNF class

<table>
<thead>
<tr>
<th>Prison</th>
<th>Antidepressants</th>
<th>Antipsychotics</th>
<th>Hypnotics/Anxiolytics</th>
<th>Any mental health</th>
<th>Any substance dependence</th>
<th>Any physical health</th>
<th>Any prescribed medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>12% (32)</td>
<td>1% (2)</td>
<td>9% (24)</td>
<td>22% (56)</td>
<td>20% (51)</td>
<td>17% (45)</td>
<td>43% (111)</td>
</tr>
<tr>
<td>B</td>
<td>12% (37)</td>
<td>5% (15)</td>
<td>6% (18)</td>
<td>17% (51)</td>
<td>16% (49)</td>
<td>21% (64)</td>
<td>41% (123)</td>
</tr>
<tr>
<td>C</td>
<td>21% (14)</td>
<td>3% (2)</td>
<td>20% (13)</td>
<td>35% (23)</td>
<td>32% (21)</td>
<td>30% (20)</td>
<td>62% (41)</td>
</tr>
<tr>
<td>D</td>
<td>11% (34)</td>
<td>4% (11)</td>
<td>4% (13)</td>
<td>16% (46)</td>
<td>11% (33)</td>
<td>19% (55)</td>
<td>34% (100)</td>
</tr>
<tr>
<td>E</td>
<td>6% (5)</td>
<td>2% (2)</td>
<td>6% (5)</td>
<td>10% (9)</td>
<td>2% (2)</td>
<td>12% (10)</td>
<td>22% (19)</td>
</tr>
<tr>
<td>All</td>
<td>12% (122)</td>
<td>3% (32)</td>
<td>7% (73)</td>
<td>18% (185)</td>
<td>15% (156)</td>
<td>19% (194)</td>
<td>39% (394)</td>
</tr>
</tbody>
</table>

Across the five prisons 39% (n=394) of newly received prisoners reported currently being in receipt of prescribed medication; prisoners at the YOI establishment were the least likely to report being in receipt of a current prescription (22%), whilst prisoners at the female establishment were the most likely to report being in receipt of a prescription (62%).

Twelve percent (n=122) of newly received prisoners reported being prescribed antidepressant medication. The most commonly reported of these were mirtazapine (28%) and the selective serotonin uptake inhibitor citalopram (23%). Three percent (n=32) of new receptions reported being prescribed antipsychotic medication, half (50%) of whom reported being prescribed the atypical drug olanzapine. Seven percent (n=73) reported being prescribed hypnotic/anxiolytic medication, most commonly diazepam (71%). Overall, 18% (n=185) reported being prescribed one or more mental health medication (antidepressants, antipsychotics and/or hypnotics/ anxiolytics).

Overall, 15% (n=156) of new receptions reported being prescribed medication for substance (drug or alcohol) dependence in the community. Of these, the vast
majority were prescribed methadone (84%), a drug used to treat opioid dependence. Four prisoners (<1%) reported being prescribed medication for alcohol dependence (chlordiazepoxide).

Overall, 19% (n=194) of new receptions reported being prescribed medication for a physical health problem. Just under half (44%) of this group reported being in receipt of medication for asthma, predominantly salbutamol (38%) or beclometason (18%) inhalers. Furthermore 18% of these were using prescribed analgesic painkillers, such as codeine or tramadol.

### 3.2 Prescribed medication use amongst audit cases

Amongst the 394 audit cases that reported being in receipt of prescribed medication, it was common for prisoners to report being in receipt of more than one type of medication (range 1-10; mean 1.8). Approximately half (53%) reported being in receipt of just one medication; 27% reported taking two medications and a fifth (20%) reported taking three or more medications. In total the 394 audit cases reported being on a total of 711 medications. Table 3 shows the proportion of these medications from each BNF class by prison.

#### Table 3: Number of separate medications reported at reception into custody by BNF class

| Prison | Anti-depressants | Anti-psychotics | Hypnotics/ | Any mental | Any substance | Any physical | Any prescribed |
|--------|------------------|-----------------| anxiolytics 5 | health     | dependence   | health       | medication |
| A      | 18% (32)         | 1% (2)          | 14% (26)    | 33% (60)   | 27% (51)     | 40% (73)     | 100% (183)   |
| B      | 16% (38)         | 7% (16)         | 9% (21)     | 32% (75)   | 21% (49)     | 48% (113)    | 100% (236)   |
| C      | 15% (14)         | 2% (2)          | 18% (16)    | 35% (32)   | 23% (21)     | 42% (38)     | 100% (91)    |
| D      | 21% (35)         | 7% (12)         | 8% (14)     | 36% (61)   | 19% (33)     | 46% (78)     | 100% (170)   |
| E      | 16% (5)          | 6% (2)          | 16% (5)     | 35% (12)   | 6% (2)       | 55% (17)     | 100% (31)    |
| All    | 17% (124)        | 5% (34)         | 12% (82)    | 34% (240)  | 22% (156)    | 45% (319)    | 100% (711)   |

Overall, 45% of the individual prescribed medications reported at reception were for physical health disorder, 34% were for mental health disorder and 22% were for substance dependence (Table 3). The proportion of medications prescribed for mental health disorder was relatively stable across individual establishments (32%-

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5 Note that in the four cases where prisoners reported being prescribed chlordiazepoxide prior to custody, which is a drug in the benzodiazepine family commonly prescribed for alcohol dependence, this was included in both the hypnotic/anxiolytic and substance dependence categories.
The proportion of hypnotics/anxiolytics was highest at the female establishment (18%). The proportion of medications for substance dependence was lowest at the YOI establishment (6%).

Figure 1 below illustrates the different combinations of medication prisoners reported being on at reception into custody.

**Figure 1: Prisoners reporting to have been in receipt of prescribed medication immediately prior to custody: combinations of medication types**

Figure 1 shows that overall, 21% of audit cases were in receipt of medication for substance dependence alone, 27% were in receipt of medication for physical health problems alone and 21% were in receipt of medication for mental health problems alone. Thus, 31% were receiving medication for some combination of physical health, mental health or substance dependence problems.

### 3.3 Standard 1: contact with community prescribers

Overall, contact with any community prescriber was documented in the clinical records of 189 (48%) of audit cases, although this varied across individual establishments (range 30%-89%).

For each of the 156 cases where a prisoner reported being in receipt of prescribed medication for substance dependence prior to custody, records were checked to establish whether contact was made with a community prescriber on the same day as, or day after reception into custody. Table 4 reports the proportion of cases at each prison where Standard 1 was met.
Table 4: Prescribed medication for substance dependence: percentage of cases where contact was made with a community prescriber by time period

<table>
<thead>
<tr>
<th>Prison</th>
<th>Cumulative percentage</th>
<th>Missing</th>
<th>No recorded contact</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same/next day</td>
<td>Within 3 days</td>
<td>Within 7 days</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>A</td>
<td>47% (24)</td>
<td>67% (34)</td>
<td>80% (41)</td>
<td>84% (43)</td>
</tr>
<tr>
<td>B</td>
<td>12% (6)</td>
<td>14% (7)</td>
<td>16% (8)</td>
<td>22% (11)</td>
</tr>
<tr>
<td>C</td>
<td>81% (17)</td>
<td>90% (19)</td>
<td>95% (20)</td>
<td>100% (21)</td>
</tr>
<tr>
<td>D</td>
<td>9% (3)</td>
<td>9% (3)</td>
<td>12% (4)</td>
<td>15% (5)</td>
</tr>
<tr>
<td>E</td>
<td>50% (1)</td>
<td>100% (2)</td>
<td>100% (2)</td>
<td>100% (2)</td>
</tr>
<tr>
<td>All</td>
<td>33% (51)</td>
<td>42% (65)</td>
<td>48% (75)</td>
<td>50% (78)</td>
</tr>
</tbody>
</table>

Of those that reported being prescribed medication for substance dependence, contact was made on the same day as, or day after reception into custody in 33% of cases, although this varied across individual establishments (range 9%-81%).

For each of the remaining 238 cases where a prisoner reported being in receipt of any other prescribed medication prior to custody (excluding medication for substance dependence), records were checked to establish whether contact was made with a community prescriber within one month. Table 5 reports the proportion of cases at each prison where Standard 1 was met.

Table 5: All other prescribed medication (excl. medication for substance dependence): percentage of cases where contact was made with a community prescriber by time period and prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Cumulative percentage</th>
<th>Missing</th>
<th>No recorded contact</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same/next day</td>
<td>Within 3 days</td>
<td>Within 7 days</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>A</td>
<td>18% (11)</td>
<td>25% (15)</td>
<td>43% (26)</td>
<td>53% (32)</td>
</tr>
<tr>
<td>B</td>
<td>24% (18)</td>
<td>26% (19)</td>
<td>28% (21)</td>
<td>38% (28)</td>
</tr>
<tr>
<td>C</td>
<td>40% (8)</td>
<td>55% (11)</td>
<td>55% (11)</td>
<td>75% (15)</td>
</tr>
<tr>
<td>D</td>
<td>19% (13)</td>
<td>25% (17)</td>
<td>31% (21)</td>
<td>37% (25)</td>
</tr>
<tr>
<td>E</td>
<td>18% (3)</td>
<td>29% (5)</td>
<td>35% (6)</td>
<td>41% (7)</td>
</tr>
<tr>
<td>All</td>
<td>22% (53)</td>
<td>28% (67)</td>
<td>36% (85)</td>
<td>41% (97)</td>
</tr>
</tbody>
</table>
Of those that reported being prescribed any other medication (excluding medication for substance dependence), contact was made within a month of reception into custody in 41% of cases, although this varied across individual establishments (range 37%-75%).

### 3.4 Standard 2: prescribing decisions

In respect of each of the 711 separate medications reported by prisoners at reception, clinical records were searched for evidence of a decision relating to either the continuation or discontinuation of that medication in custody. Table 6 shows the proportion of cases where medication was prescribed or not prescribed (with and without a documented reason) within a month of reception into custody.

<table>
<thead>
<tr>
<th>Prison</th>
<th>Prescribed</th>
<th>Not prescribed</th>
<th>Missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>81% (149)</td>
<td>16% (30)</td>
<td>2% (4)</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>72% (170)</td>
<td>13% (31)</td>
<td>11% (27)</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>78% (71)</td>
<td>18% (16)</td>
<td>4% (4)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>59% (100)</td>
<td>32% (55)</td>
<td>9% (15)</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>58% (18)</td>
<td>29% (9)</td>
<td>13% (4)</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>71% (508)</td>
<td>20% (141)</td>
<td>8% (54)</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>71% (508)</td>
<td>20% (141)</td>
<td>8% (54)</td>
<td></td>
</tr>
</tbody>
</table>

Overall, 71% of all medications reported at reception were re-prescribed within a month of reception into custody (Table 6). Where medication was re-prescribed, in 70% of cases it was done so on the day of reception into custody, or the next day.

Twenty-seven percent (n=195) of all medications reported at reception were not re-prescribed within a month of reception into custody. In 72% of these cases a documented reason for this was available in the notes. Most common reasons included: offer of substitute medication (55%), patient refusal of medication (4%) and where medication was ‘disconfirmed’ (i.e. the community prescriber had responded that the prisoner did not have a current, valid prescription for such medication; 24%). However, in 28% of cases (n=54) there was no documented reason for the prisoner not being prescribed their pre-custody medication available in the notes.

Overall, in 91% of cases standard two was met: in 71% of cases medications were re-prescribed within a month of reception into custody and in a further 20% of cases medications were not re-prescribed, with a reason for this documented in the...
notes. In 8% (n=54) of cases standard two was not met. Closer analysis of these 54 cases highlighted a number of interesting findings:

- In 40 (74%) cases the prison had not contacted the community prescriber to confirm the prescription; in a further 14 (26%) cases community prescribers had confirmed the prescription as correct.
- In 26 (50%) cases, the prisoner came from Prison B.
- The most frequently non-prescribed class of medication (33%; n=18) was medication for asthma (e.g. salbutamol and beclometasone inhalers), followed by antidepressants and hypnotics/anxiolytics (both 20%; n=11).
- Medication for mental health problems accounted for 34% of medications reported at reception overall, and 46% (n=25) of all non-prescribed medications.
- In 11 (20%) cases prisoners were in custody three days or less. Overall, however, in 30 (56%) cases the prisoner was in custody for a month or longer.
- In two cases the prisoner had not been able to identify the name or address of their GP.

3.5 Standard 3: the continuation of medication for mental health problems

The third standard guiding this audit specifically concerns those received into custody with medication prescribed for mental disorder. Overall, 185 prisoners reported being prescribed psychotropic (antidepressant, antipsychotic and/or hypnotic/anxiolytic) medication (Table 2), identifying a total of 240 separate medications (Table 3).

All cases where, within the first week of custody, the community prescriber confirmed that there was no current, valid prescription for the medication were excluded from this analysis. To do this, we first established the number of cases where the prison contacted a community prescriber about medication (n=108). In 85% (n=92) of these cases, we found evidence that the prison received a response from a community prescriber. In total, responses from community prescribers regarding 103 separate psychotropic medications were noted. Table 9 in Appendix 3 shows the distribution of these responses by BNF class. In 61% of cases the prescription was confirmed as a current medication. Hypnotics/anxiolytics were the least frequently confirmed psychotropic medication (51%). Overall, 33 separate psychotropic medications were disconfirmed by community prescribers, 27 within a week of reception into custody. The latter (n=27) were excluded from the analysis. Table 7 describes the findings of this analysis in the remaining 213 cases.
Table 7: Continuation of medication for mental health disorder: percentage of cases which met standard three by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>(n)</td>
<td></td>
<td>(n)</td>
</tr>
<tr>
<td>A</td>
<td>80%</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(43)</td>
<td>(11)</td>
<td>(54)</td>
</tr>
<tr>
<td>B</td>
<td>69%</td>
<td>31%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(45)</td>
<td>(20)</td>
<td>(65)</td>
</tr>
<tr>
<td>C</td>
<td>68%</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(19)</td>
<td>(9)</td>
<td>(28)</td>
</tr>
<tr>
<td>D</td>
<td>44%</td>
<td>56%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(24)</td>
<td>(31)</td>
<td>(55)</td>
</tr>
<tr>
<td>E</td>
<td>45%</td>
<td>55%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(5)</td>
<td>(6)</td>
<td>(11)</td>
</tr>
<tr>
<td>All</td>
<td>64%</td>
<td>36%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(136)</td>
<td>(77)</td>
<td>(213)</td>
</tr>
</tbody>
</table>

In 64% (n=136) of cases where prisoners reported being in receipt of prescribed psychotropic medication prior to custody, the standard was met.

- In 59% (n=125) cases the medication was prescribed in the first week of custody, whether or not the community prescriber was contacted.
- In 5% (n=11) cases the medication was not prescribed in the first week of custody, but there was evidence of a formal psychiatric assessment within the first week of custody.

A preliminary analysis of the 77 cases where the standard was not met has highlighted a number of interesting findings, including the following:

- The most frequently discontinued mental health medication was diazepam (n=18), followed by zopiclone (n=9) and citalopram (n=8).
- In 17 (22%) of cases prisoners were in custody for a period of seven days or less. Overall, however, in 51 (66%) cases the prisoner was in for a month or longer.
- In 39 (51%) cases no attempt to contact the community prescriber was documented.
- In 41 (53%) cases the prisoner was seen by the medical officer in their first month of custody.
- In 22 (29%) cases a substitute was prescribed.
3.6 Summary of findings

A summary of the proportion of cases in which each of the three audit standards was met in provided below.

Table 8: Summary of audit findings

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percentage of cases where standard was met</th>
</tr>
</thead>
</table>
| 1        | Substance dependence: **33%**  
           | All other: **41%**  
           | *(Tables 4 & 5)* |
| 2        | **91%**  
           | *(Table 6)* |
| 3        | **64%**  
           | *(Table 7)* |

The key findings from this study can be summarised as follows.

- Thirty-nine percent of newly received prisoners reported that they were currently in receipt of prescribed medication.
- Contact with community prescribers within a month of reception was documented in 48% of audit cases overall, although this varied across individual establishments (range 9%-81%).
- Seventy-one percent of all medications reported at reception were re-prescribed within a month of reception into custody. In 70% of such cases medication was prescribed on the day of reception, or the next day.
- In 20% of cases, medication was not prescribed in the first month of custody. In 72% of these cases there was a documented reason for this available in the notes; most commonly patients were offered an apparently appropriate substitute medication or the medication was disconfirmed by the community prescriber. In 8% of cases (n=54) no documented reason was available.
- Where prisoners reported being in receipt of prescribed mental health medication prior to custody, within a week of coming into custody prescriptions were continued in 59% of cases and deemed unnecessary as a result of psychiatric assessment in a further 5% of cases.
4 Discussion

Prisoners should have access to ‘the same quality and range of health care services as the general public receives from the NHS’ (HAC, 1997). With regard to medication, the continuation of prescriptions for newly received prisoners is arguably one of the most direct measures of equivalence between prison and community settings. Data on prescribing practices are limited; however, one study found that two thirds of prisoners received into custody with current prescriptions of psychotropic medication did not receive that medication during their first month in custody (Shaw et al., 2006). This audit aimed to measure the extent to which standards relating to prescribing medication for newly received prisoners were being met in a sample of English prisons.

This audit had a number of strengths. We were able to access 95% of those records eligible for inclusion, which increases our confidence in the representativeness of the sample. Also, we sampled records from a range of prisons in varying locations with different offender populations. However, it was not without its limitations. Firstly, we were only able to capture activity that was recorded in prisoners’ clinical records. We did not cross-check data with additional sources, such as interviews with prisoners or staff, or consider data on the dispensing and administration of medication. Thus, it is possible that in some cases medication was prescribed, but never actually received by the prisoner. Furthermore any unrecorded prescribing activity, data in records held elsewhere or illegible notes would have been missed. Nonetheless, all prescribing should be recorded in medical records and we made best use of the data available to us.

The validity and value of the standards we adopted for this audit must be considered. There appears to be a lack of specific policy guidance in relation to the verification and continuation of medication for new prisoners. Most available literature is not specific to prison settings and lacks precision, for example in relation to the timescales for completion of procedures. Whilst we have used our judgement and provided justification for each of the three standards we developed for this audit, it may be that these require further consideration if to be used across the full variety of settings and populations found in the UK prison estate. Notwithstanding these limitations, we believe this study represents a useful contribution to the literature and a starting point for further discussion between practitioners and policy makers.

Standard one of the audit concerned contact between prison and community prescribers to verify newly received prisoners’ prescriptions. Where individuals reported being prescribed medication for substance dependence, evidence of contact with community prescribers on the day of reception/next day was available in 33% of cases. For individuals receiving all other types of medication, a more relaxed time limit of one month following reception into custody was used, which was met in 41% of cases. These results suggest that in a large proportion of cases, timely contact with prescribers was not made. At the very least, this can be
regarded as a missed opportunity to gather and evaluate relevant information amongst those planning and delivering care in custody. If, however, immediate health needs are missed, in some cases failure to act could have serious consequences for the prisoner, and indeed the prison if such behaviour is viewed as negligent. In most cases medications were re-prescribed in custody, whether or not the community prescriber was contacted. Yet we noted that in a significant proportion of cases where a response was received from prescribers, the prescription reported by the prisoner at reception was wrong. Thus, taking steps to verify prescriptions is a worthwhile activity and one that can help to protect health and safety.

The second standard of the audit was used to establish whether or not a formal decision regarding the prescription of medication in prison was recorded in the notes. This standard was met in 91% of cases. Whilst this appears encouraging, it is important to acknowledge that this figure includes any recorded decision within a month, irrespective of clinical utility. For example, this included cases where an initial decision was made to verify prescriptions with community prescribers before reissuing medication; however a response was never received and the medication was not re-prescribed in custody by omission, rather than as a result of positive clinical assessment or active decision making. In five cases medication was not re-prescribed until two weeks after reception into custody. Thus, whilst we can make a preliminary judgement that decisions about medication were made and recorded in the majority of cases, further work is needed in order to determine the quality of the decisions made.

Standard three specifically addressed prisoners received into custody reporting medication for mental disorder. This study was limited in that it was deemed too problematic to define which of the audit cases actually had a mental disorder; rather, the standard was applied to all those that reported being prescribed antidepressants, antipsychotics or hypnotics/anxiolytics. In 64% of cases the standard was met, meaning that the majority of pre-custody psychotropic medications were re-prescribed in prison, unless and until deemed unnecessary as a result of psychiatric assessment. In the remaining third (36%) of cases prisoners received neither their medication, nor a psychiatric assessment in their first week of custody. Authors have reported previously that prisoners complain of being denied prescribed psychotropic medication on reception into custody (Shaw et al, 2007; Plugge et al, 2008; Bowen et al, 2009). This audit has shown that in a third of cases there was no clear reason why prisoners did not receive their pre-custody medication was documented. Given these findings and those of previous studies indicating prisoners’ dissatisfaction with the situation, this area arguably warrants further attention.

We did note that in half (53%) of cases where standard three was not met, prisoners had seen the prison GP in their first month of being in custody. Although for the purposes of the audit, this did not constitute a psychiatric assessment, the GP may have decided to discontinue medication. Indeed, in the community many common mental disorders (e.g. major depressive disorder) are routinely and competently dealt with within primary care. A study undertaken in one local adult prison found that approximately half of those diagnosed with a mental illness could
safely be treated within primary care (Senior, 2005). Thus, it is questionable whether individuals prescribed psychotropics automatically warrant referral to specialist mental health services once in prison. Secondary mental healthcare services in prison, such as in-reach, are not yet consistently supported by primary mental healthcare services (Steel et al, 2007; HMIP, 2007). Changing the Outlook (DH, 2001), from which standard three was taken, focuses on rolling out provision of secondary mental healthcare services. More up-to-date, specific advice in this area recognising the need for both equivalence and proportionality when treating those with mental health disorders in prison may be a welcome addition to the available policy literature.

The process of conducting this study raised a number of interesting points regarding broader processes and systems associated with prescribing. Notably, all but one prison had implemented an electronic clinical records system. This generally made access to clinical records faster and easier, and the data collection process quicker. Electronic clinical information systems will shortly be rolled out across the estate. They should not, however, be regarded as a panacea for problems with clinical record keeping and sharing. In some establishments, particularly those using a combination of paper and electronic records, information about medication was still not available in a single, accessible location.

The second issue concerns the identification and delegation of tasks following reception screening. With regard to contacting community prescribers, the prisons that performed well in this part of the audit tended to have clearer processes about the task order and flow of information when arranging medication. They were also able to identify individuals who routinely performed each of these tasks. Most prisons had a system for initially identifying which prescriptions needed to be confirmed. For example, one prison usefully set up their electronic clinical records system to create ‘alerts’ for healthcare administrative staff to contact community prescribers. However, those prisons that performed better in the audit also appeared to have robust systems for communicating the results of any enquiries back to prison based prescribers so that a decision could be made regarding continuation of medication in custody.

A third issue concerns the importance of the timely flow of communication between patients, prescribers, and other healthcare staff. Communication between prisons and community prescribers was sometimes not straightforward. Prisons reported that prescribers had different protocols regarding the sharing of prescription information, and that some were quicker and more consistent than others in responding to requests for information. Furthermore, staff noted that sometimes prisoners could not identify their current GP, making it difficult to verify prescriptions. One prison successfully dealt with such cases by subscribing to the National Strategic Tracing Service (NSTS), a database which permits authorised users to look up GP details for individual patients. Communication between prison healthcare staff was also important. In a number of cases mental health workers chased up community prescribers for verification of pre-custody medications and arranged for prescriptions to be issued by the prison GP. Such occasions, however, were usually following mental health assessments which were typically arranged weeks (rather than days) following reception into custody. By this time some
prisoners had already missed medication for significant periods of time. Keeping lines of communication between prisoners and staff also appeared to be important. Following health reception screening, prisoners may struggle to inform healthcare staff of their medication needs. One prison had a well-publicised telephone enquiry service whereby prisoners could call the healthcare centre and verbally request that their pre-custody medication be prescribed. This was seen to work well and anecdotally had highlighted occasions where prescriptions had been overlooked.

In summary, this audit has shown that the effectiveness and timeliness of processes associated with verifying prescriptions and arranging medication for newly received prisoners varied from prison to prison. Whilst most prisoners receiving psychotropic medication in the community are promptly given either their medication or a psychiatric assessment in custody, there remains a significant proportion of prisoners that receive neither. Previous studies suggest that early custody is a distressing time for many prisoners and that discontinuation of medication remains a significant area of discontentment. Given these findings and those of previous studies, this is an area that arguably warrants attention and action.
5 Recommendations

The process of conducting this audit has highlighted areas for improvement and of good practice. Acknowledging this, we recommend the following:

1. Where a newly received prisoner reports currently being in receipt of prescribed medication prior to custody, prisons should contact the relevant prescriber to verify prescription claims. This should happen in every case, unless the prisoner is well known to services or reliable alternative evidence is available (e.g. the prisoner is in possession of a valid copy of their current prescription).

2. We recommend that prisons should aim to verify prescriptions for newly received prisoners by the end of the working day following reception into custody. This target should be communicated to staff, included within written training materials, policies and procedures, and be subject to routine audit.

3. Responsibility for verifying the prescriptions of newly received prisoners should be delegated to a named person, or persons. This person should also have responsibility for communicating the findings of any enquiries back to the prison GP (or other named prescriber). The results of any enquiries made should be recorded clearly in the notes.

4. Where prison staff are not able to locate community prescribers or obtain verification within this time, the prisoner should be re-assessed in custody by an appropriate qualified individual in order to determine whether or not a new prescription should be issued. The results of this assessment should be recorded clearly in the notes.

5. Prisoners with prescriptions for medication for mental health problems, verified by community prescribers, should continue to receive their prescribed medication in prison, unless and until deemed unnecessary as a result of psychiatric, or other appropriate assessment.

6. Healthcare teams should consider the range of ways that prisoners can make contact with them regarding medication queries (e.g. applications, via telephone). The ways in which prisoners can contact healthcare should be clearly described in any literature on healthcare services given to newly received prisoners.

7. Prisons with, or planning to use, electronic clinical records systems should consider what clinical information is recorded and stored in paper form, and how this can be made accessible to the full range of healthcare staff that require access, including upon transfer/discharge.
6 References


Academy of Medical Royal Colleges. 2008b. A clinician’s guide to record standards - Part 2: standards for the structure and content of medical records and communications when patients are admitted to hospital. London: Academy of Medical Royal Colleges.


# 7 Appendices

## Appendix 1: Audit form

### FORM C: AUDIT TRACKING FORM

**REPORTED MEDICATION NEEDS AT RECEPTION:**

1. What prescribed medication did the patient report being in receipt of immediately prior to custody? **Please state each drug below**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. At reception is the patient noted as (tick as many as apply):

- Ever having been in contact with community mental health (MH) services
- Having been in contact with mental health services immediately prior to custody
- Ever having been an inpatient in a psychiatric hospital
- Ever having received medication for a mental health problem
- Having brought their medication with them
- Having been in contact with a drug service immediately prior to custody
- Having recently been hospitalised/ had an operation

### PRESCRIPTION VERIFICATION:

3. Is there any evidence of the prison contacting the community prescriber to confirm the patient’s medication needs?
   - No [ ] If no, go to question 5 [ ] Yes [ ] Prescriber: ______ Date: ______

4. Is there any evidence of the prison having received a response from the community prescriber?
   - No [ ] If no, go to question 5 [ ] Yes [ ] Date: ______

If response was received, report the outcome for each drug reported in Q1:

<table>
<thead>
<tr>
<th>Drug 1</th>
<th>Drug 2</th>
<th>Drug 3</th>
<th>Drug 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>药1</td>
<td>药2</td>
<td>药3</td>
<td>药4</td>
</tr>
<tr>
<td>Drug &amp; dose correct</td>
<td>Drug &amp; dose correct</td>
<td>Drug &amp; dose correct</td>
<td>Drug &amp; dose correct</td>
</tr>
<tr>
<td>Wrong drug/dose</td>
<td>Wrong drug/dose</td>
<td>Wrong drug/dose</td>
<td>Wrong drug/dose</td>
</tr>
<tr>
<td>state correct</td>
<td>state correct</td>
<td>state correct</td>
<td>state correct</td>
</tr>
<tr>
<td>pt not px this drug</td>
<td>pt not px this drug</td>
<td>pt not px this drug</td>
<td>pt not px this drug</td>
</tr>
<tr>
<td>Pt px drug in past - no current px</td>
<td>Pt px drug in past - no current px</td>
<td>Pt px drug in past - no current px</td>
<td>Pt px drug in past - no current px</td>
</tr>
<tr>
<td>Missing</td>
<td>Missing</td>
<td>Missing</td>
<td>Missing</td>
</tr>
<tr>
<td>Other -state</td>
<td>Other -state</td>
<td>Other -state</td>
<td>Other -state</td>
</tr>
</tbody>
</table>

### PSYCHIATRIC ASSESSMENT & MEDICATION REVIEW IN PRISON:

5. Please state all medications (or substitutes) px within a month of reception:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Date first px</th>
<th>Px type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. For any medications confirmed but not prescribed, state why not:

7. Did a mental health assessment take place within a month of reception?
   - No [ ]
   - Yes [ ]

   a) Date: ______
   b) With whom: ____________________________

   Outcome: ____________________________

   Please tick if medication was discussed: [ ]

8. Within a month of reception, is the patient ever noted as (tick as many as apply):

- Seeing the GP (post-reception)
- Seeing the prison psychiatrist
- Being under the care of in-reach
- Being on CPA
- Being on an ACCT

Completed by: ____________________________

Data inputted: [ ]
### Appendix 2: BNF medication classifications

<table>
<thead>
<tr>
<th>Medication class</th>
<th>BNF section</th>
<th>Examples of commonly prescribed medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics</td>
<td>4.7</td>
<td>Co-codamol, Dihydrocodeine</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>4.3</td>
<td>Citalopram, Fluoxetine, Mirtazapine.</td>
</tr>
<tr>
<td>Antiepileptics</td>
<td>4.8</td>
<td>Carbamazepine, Gabapentin.</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>4.2</td>
<td>Chlorpromazine, Haloperidol, Olanzapine, Risperidone.</td>
</tr>
<tr>
<td>Cardiovascular system</td>
<td>2</td>
<td>Simvastatin, Warfarin.</td>
</tr>
<tr>
<td>Central nervous system stimulants and drugs used for attention deficit hyperactivity disorder</td>
<td>4.4</td>
<td>Methylfenidate Hydrochloride.</td>
</tr>
<tr>
<td>Drugs used in substance dependence</td>
<td>4.10</td>
<td>Buprenorphine, Methadone.</td>
</tr>
<tr>
<td>Endocrine system</td>
<td>6</td>
<td>Insulin, Metformin.</td>
</tr>
<tr>
<td>Gastro-intestinal system</td>
<td>1</td>
<td>Esomeprazole, Lansoprazole.</td>
</tr>
<tr>
<td>Hypnotics/ anxiolytics</td>
<td>4.1</td>
<td>Diazepam, Temazepam, Zopiclone.</td>
</tr>
<tr>
<td>Infections</td>
<td>5</td>
<td>Benzylpenicillin, Metronidazole.</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>3</td>
<td>Beclometasone, Salbutamol.</td>
</tr>
</tbody>
</table>
Appendix 3: Additional analyses

Table 9: Community prescriber responses by BNF class

<table>
<thead>
<tr>
<th>Medication class</th>
<th>Drug &amp; dose correct</th>
<th>Wrong dose</th>
<th>No current prescription</th>
<th>Prescription newly identified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>67% (34)</td>
<td>2% (1)</td>
<td>24% (12)</td>
<td>6% (3)</td>
<td>100% (50)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>63% (10)</td>
<td>6% (1)</td>
<td>31% (5)</td>
<td>0% (0)</td>
<td>100% (16)</td>
</tr>
<tr>
<td>Hypnotics/anxiolytics</td>
<td>51% (19)</td>
<td>5% (2)</td>
<td>43% (16)</td>
<td>0% (0)</td>
<td>100% (37)</td>
</tr>
<tr>
<td>All</td>
<td>61% (63)</td>
<td>4% (4)</td>
<td>32% (33)</td>
<td>3% (3)</td>
<td>100% (103)</td>
</tr>
</tbody>
</table>

*Cases where the prisoner had not known the drug name at reception and the community prescriber had responded by providing a name.*
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