RCGP Safer Prescribing in Prisons – Top Tips

Introduction

This Top Tips document is written as a short accompaniment to the RCGP SEG Safer Prescribing in Prisons, 2nd Edition, January 2019. There is an extended section on psychosis, expanded from the original chapter published. There are reference lists in the original document which can be found at: rcgp.org.uk/policy/rcgp-policy-areas/prison-medicine.aspx

Prescribing decisions in prison and other secure environments should be patient-centred and made in the context of promoting self-care, non-pharmacological treatments and encouraging changes in lifestyle to promote health and wellbeing.

Prescribing can be challenging due to the complexity of patient needs, the structural and operational limits of secure environments and the risks to the individual and the wider prison population associated with abuse and diversion of prescribed medicines and other illicit substances.

Medicines may be requested for their psychotropic or other desirable effect rather than their therapeutic or licensed use, often but not always by patients with a previous history of substance misuse. They may be diverted by trading or selling into to the illicit prison economy and can play a part in perpetuating bullying, violence and other maladaptive and criminal behaviours by individuals, groups or gangs.

Diverted prescription medicines may cause significant harm to others as a result of side effects, overdose or interactions with other substances. If diversion is a result of coercion of an individual whose medicine has been prescribed appropriately, doses missed due to diversion may have a direct negative impact on the health of that individual.

It may be necessary to de-prescribe medicines that have been started in community primary care settings, in hospital, or in another prison where there is little or no ongoing clinical indication for their use or where the safety of the individual patient and the wider prison population is compromised. It is important when de-prescribing to do so safely and to manage emerging symptoms with safer pharmacological or non-pharmacological options, aiming to maintain equivalence of effect, equivalence of practice and equivalence of outcome wherever possible.

Prescribing within a governance framework

Royal Pharmaceutical Society (RPS) professional standards (2017) identify the multi-disciplinary medicines governance framework and workforce competencies required in prisons for the optimisation of patient medicines.

Clinical decisions to continue or stop medicines on admission into prison need to be considered on an individual case basis. Evidence based assessment of risk versus benefit to the individual patient should inform prescribing decisions rather than a generic approach to stopping specific medicines.

Assessment of immediate health needs, available medication history, the risk of omitting or delaying doses and any safety alerts should all be taken into account when making

immediate prescribing decisions in reception. NICE guidance (NG57) gives examples of critical medicines that may cause harm if ceased abruptly or if doses are missed.

Outcomes from a medicines reconciliation completed within 72 hours of admission should be used to review on-admission medication. Further details of hospital letters and investigation results from community primary care may need to be requested from community primary care to clarify why a medicine was started. Prescribing practice identified as inappropriate or unsafe on review of a patient should be addressed skilfully.

The in-possession status of the patient in prison should be established using the national in-possession template on SystmOne and in collaboration with the prison. Prescribing should be in line with the in-possession status of the patient and in line with the local in-possession policy.

The risk to a patient of having in-possession (IP) medicines may change during their stay in prison and their IP status may need to be reassessed. For example, on reception into prison, a patient may feel distressed and vulnerable to self-harm and therefore require supervision of their medicines. They will start with a not-in-possession (NIP) or 'see to take'(STT) status. As they adjust, they may become more stable and able to safely self-administer medication and be able to have their medicines' status changed from NIP to IP. Equally, if a patient who self-administers medicines is found to have abused them, had difficulty adhering to the dosing schedule, to be at risk of self-harm or had an ACCT opened, their IP status may need to be changed to NIP/STT. **It is important to ensure appropriate information sharing to minimise the risk of overdose of medicines that may be prescribed and also available on the canteen (e.g. paracetamol). Prison staff have a safeguarding duty to ensure that residents on an ACCT, at risk of overdose, are prevented from buying supplies of paracetamol from the canteen**.

On transfer or release, accurate information about the health of a patient including current doses of any prescribed medicines should be communicated in a timely way to the receiving prison, community GP practice or hospital taking over the care of the patient. A seven day supply of medicines including controlled drugs (CDs) (except buprenorphine or methadone on transfer) should be provided (prescribed as 'to take out' (TTO)). If the release is unplanned (e.g. from court) and TTOs cannot be supplied, the prescriber can write an FP10 or FP10MDA for the patient to take to a community pharmacy. If there is concern that a patient could be at risk from a 7-day script or supply of a particular medicine that cannot be written on an FP10MDA, post-dated FP10 scripts for shorter intervals (e.g. 1-3 days) for a total of 7 days may be provided.

Insomnia

Assessment: identify duration, type, cause, effects on functioning, risk of self-harm. Consider using a sleep diary or sleep watch to identify and confirm disrupted sleep patterns. Consider if insomnia part of a presentation of mental illness.
Management:
Non-pharmacological: (Main approach) Sleep hygiene, relaxation advice, exercise.
Pharmacological: (Only for short periods of acute distress). If prescribing:

- 1st line prescribing: sedating antihistamines (promethazine, diphenhydramine)

- 2nd line prescribing: Z-drugs (eg zopiclone, zolpidem) risk of diversion/abuse
- **DO NOT prescribe** benzodiazepines, amitriptyline or low-dose sedating antidepressants eg 15mg mirtazapine
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Depression

Assessment: Screen for depression and risk of self-harm and suicide at first-stage health assessment. Take collaborative, whole prison approach to risk. Assessment Care in Custody and Teamwork (ACCT) if required.
Management: Stepped care model – see NICE guidance CG90
Non-pharmacological: Steps 1-4 use increasing intensity psychological interventions
Pharmacological: Steps 2-4 usually only in moderate or severe depression, combined with psychological intervention; monitor closely <30y (particular risk self-harm/suicidal thoughts on initiation); supervised consumption of medicines at risk of abuse and diversion; orodispersible where possible - less easily concealed

- 1st line prescribing: SSRI better tolerated, safer in overdose
  - fluoxetine less suitable if chronic physical health problems
  - sertraline
  - citalopram, escitalopram avoid with methadone/other QTc lengthening drugs
- 2nd line prescribing:
  - paroxetine less suitable physical health problems; withdrawal symptoms
    trazodone risk diversion/abuse due to sedation; withdrawal symptoms
  - venlafaxine check BP before/during treatment. Avoid if uncontrolled BP, risk arrhythmia, recent MI
- 2nd/3rd line only: mirtazapine diversion/abuse risk due to sedation.
- **DO NOT prescribe:** amitriptyline, dosulepin (cardiotoxic, risk fatal overdose)

Anxiety

Assessment: Screen for anxiety at first-stage health assessment. Presentation may be influenced by co-morbid disorders. Drugs or alcohol may have been used prior to custody as self-medication. Prison environment may trigger or exacerbate anxiety.
Management: Depends on specific type of anxiety; Stepped care model – see NICE guidance (CG123 Common Mental Health Problems; CG113 GAD, panic; NG116 PTSD; CG31 OCD, BDD; Social anxiety CG159)
Non-pharmacological: **mainstay of treatment**; psychological interventions specific to type of anxiety.
Pharmacological: combined with psychological intervention; specific to type of anxiety; supervised consumption of medicines at risk of abuse and diversion

- 1st line prescribing: SSRI
  - sertraline panic, PTSD, social anxiety, OCD
  - citalopram panic; avoid with methadone/other QTc lengthening drugs
  - escitalopram GAD, OCD, panic, social anxiety; avoid with methadone/other QTc lengthening drugs
  - fluoxetine OCD; less suitable if chronic physical health problems
- 2nd line prescribing:
  - SNRI: duloxetine GAD, venlafaxine GAD, social anxiety; BP/cardiac risks
  - paroxetine social anxiety, PTSD, GAD, OCD, panic; withdrawal symptoms
  - propranolol autonomic symptom management only
  - buspirone short term use, not if on benzodiazepine, chlorpromazine short term use severe anxiety, agitation, violent – see BNF

    - clomipramine psychiatrist input, phobias, obsessional state
- **DO NOT prescribe:** Benzodiazepines (except short term, acute severe), antipsychotics (except specific indication), tricyclic antidepressants (except see above) mirtazapine, trazodone, pregabalin, sedating antihistamines (clinical safety or diversion risks)

Substance misuse

Assessment: Screen for use and misuse of alcohol, illicit and prescribed drugs at first-stage health assessment; use validated clinical tools to assess withdrawal symptoms and presence of dependence and carry out urine drug testing in Reception.
Management:

- Ensure good communication between community, prison and healthcare teams from the point of arrival through to transfer or release, to facilitate safe, effective integrated care.
- Initiate care planning and treatment of immediate clinical need and management of self-harm and suicide risk in Reception.
- Set the expectation that all medication will be reviewed and where necessary, changes made to prescribing to meet current clinical need and address safety where risk to the patient is identified.
- Locate prisoners at risk of withdrawal or toxicity in the first five days in prison where enhanced, regular observations (at least twice daily) can be facilitated.
- Contact community pharmacy and prescribers at the earliest opportunity to confirm current prescriptions.
- Offer evidence-based psychological interventions tailored to the needs of the individual, delivered by appropriately skilled staff.
- Offer evidence-based pharmacological interventions, (see details in Clinical Guidelines on Drug Misuse and Dependence Update 2017).
- **Opioid dependence**: Use methadone as first line Opioid Substitute Therapy (OST) in prison unless someone is already stabilised on buprenorphine and has no evidence of concomitant illicit drug use. Caution with co-prescribing drugs that may increase QTc interval (avoid citalopram).
- Offer a short course (c.5 days) symptomatic relief if methadone is declined or cannot be tolerated: Consider promethazine for insomnia, NSAIDs for pain, mebeverine for abdominal cramps, metoclopramide or prochlorperazine for nausea and vomiting. Caution with hyoscine butylbromide and loperamide, both of which may be abused or diverted.
- **Benzodiazepine prescribing**: Limit benzodiazepine prescribing primarily to use in assisted withdrawal for benzodiazepine or alcohol dependence. If considering use in acute severe anxiety or agitation associated with psychosis, discuss with mental health team and limit to very short duration (less than 2 weeks) with a plan for urgent review of mental health crisis.
- **Benzodiazepine dependence**: Initiate treatment in reception, usually with diazepam, if there is a history of regular illicit benzodiazepine use for 2-4 weeks or more with positive urine results and evidence of withdrawal. If there is no evidence of withdrawal, consider close observations for emerging withdrawal symptoms rather than initiate treatment in reception. If treatment is started, agree a plan to taper the daily diazepam dose by e.g. 2mg/week. Diazepam maximum licensed daily dose is 30mg but there is rarely need to prescribe more than 20mg/day in prison which should inhibit seizures. If community benzodiazepine prescribing is confirmed, indications should be carefully reviewed and a treatment plan agreed, with involvement of appropriate specialists (e.g. mental health, neurology.)
- **Alcohol dependence**: Treatment of choice for assisted withdrawal from alcohol is thiamine, B vitamins and chlordiazepoxide (dose dependent on level of alcohol intake). If concurrent diazepam dependence, either treat with diazepam or use chlordiazepoxide

and monitor for benzodiazepine withdrawals at the end of the chlordiazepoxide assisted withdrawal. If benzodiazepine withdrawals emerge, consider continuing treatment with diazepam from 10mg/day, reducing by 2mg/week.

- If substance misuse problems develop while a person is in prison, they should be assessed and offered integrated care to meet their needs.
- **NPS/Club drugs:** The majority of NPS (new or novel psychoactive substances) used in prisons are synthetic cannabinoid receptor agonists (SCRAs) e.g Spice, Black Mamba. SCRAs have unpredictable effects. They can cause relaxation, euphoria and disinhibition but may also cause dangerous acute adverse effects, including convulsions, paralysis, tachycardia, hypotension or hypertension, psychosis, extreme bizarre behaviour, agitation and aggression. Severe harm has been reported while intoxicated including eye gouging, penis amputation, self-immolation. SCRAs are available in herbal mixture, powder and liquid form and may be sprayed on to paper. There are increasing reports of staff being affected while attending to intoxicated residents or handling papers. Use of protective equipment including gloves and masks with appropriate filters is recommended.
- **IPEDs:** Image and performance enhancing drugs (IPEDs) include anabolic steroids, growth hormones, human chorionic gonadotropin and peptide hormones. Adverse effects include cardiovascular, haematological, neurological, metabolic, hormonal, psychiatric effects, risk from incorrect labelling, contamination of drugs, harms due to injecting. Insomnia, headaches, low mood and endocrine imbalances may occur on stopping IPEDs but no specific drug therapy is recommended to manage withdrawal. Support users with harm reduction measures and specialist referral if endocrine problems develop. Be aware that insulin or oral hypoglycaemics prescribed in prison are at risk of abuse and diversion.
- **Serotonin Syndrome:** potentially life-threatening reaction due to excessive serotonin levels - should be considered in people who use illicit amphetamine-type drugs e.g. MDMA, cocaine and those prescribed drugs that increase serotonin e.g. MAOIs, tricyclic antidepressants, SSRIs, opiates (tramadol) and antiemetics.
- 3 classic features: **mental state changes** (include agitation, confusion, delirium, hallucinations, drowsiness, coma), **autonomic hyperactivity** (includes tachycardia, hypertension, hyperthermia, excessive sweating), **neuromuscular abnormalities** (includes shivering, tremor, teeth grinding, muscle rigidity, ocular clonus, seizures)
- **Prescribed Dependence Forming Medications (DFMs):** it is important to review all medications when people come in to prison to ensure there are ongoing clinical indications and that these are within the product license. If medications are prescribed with potential for dependence or misuse, consider supervised administration or compliance checks. Consider safer prescribing options, particularly for patients with problematic drug or alcohol dependencies.
- Gabapentin and pregabalin are at risk of abuse and diversion in the community and in prison. They are Schedule 3/Class C Controlled Drugs and should only be prescribed within their product license. They may increase suicidal thoughts and can cause aggression and agitation. There is a risk of respiratory depression and death with gabapentinoids, particularly in people with a history of substance misuse and taking prescribed or illicit opioids. Those at risk of respiratory depression and death should be offered safer prescribing options and an assisted withdrawal from gabapentinoids. A tapering schedule of up to 50–100mg/week pregabalin or 300mg every 4 days gabapentin may be used, although a more rapid reduction may be indicated for those at particular risk.

Epilepsy

Assessment: Screen for epilepsy at first-stage health assessment. Confirm diagnosis, specific type of epilepsy and anti-epileptic drugs (AEDs) prescribed in the community. NB

AEDs should normally have been initiated by a specialist after investigation, following more than one seizure; they are not recommended for provoked/non-epileptic seizures (NICE 2012). If there is doubt about the diagnosis of epilepsy or concerns that AEDs are being abused, a specialist neurology opinion should be requested to confirm diagnosis and optimise prescribing that is suitable and safe for the prison environment.
Management: Continue AEDs in prison that have been prescribed in line with NICE guidance and licensed indications (see BNF) in the community. Be aware that some AEDs have sedating, anxiolytic or euphoric side effects and are at risk of diversion or abuse. Caution required prescribing AEDs to women of child-bearing age – see BNF and MHRA guidance (fetal development risks e.g. sodium valproate, carbamazepine, lamotrigine, topiramate, zonisamide). Be aware of category of AED (category 1 - brand-specific; cat 3 - brands interchangeable). Caution AED side effects in prison environment (e.g. aggression, agitation, suicidal ideation with some AEDs).
1st line prescribing: **depends on type of seizure (see British National Formulary)**

- carbamazepine focal and generalised tonic-clonic seizures. Not atonic, tonic, myoclonic, absence seizures. Caution cardiac disease. MR preps reduce s/e.
- sodium valproate (men only) atonic, tonic seizures (1st line). Side effects eg liver toxicity, aggression, confusion, suicidal ideation. Monitoring (fbc, LFT)
- lamotrigine, levetiracetam Focal and generalised seizures. S/e both include aggression, agitation. Lamotrigine: may worsen Parkinson's disease, risk skin reactions, blood disorders. Levetiracetam: anxiety, depression, suicide risk.
- ethosuximide absence; s/e GI, avoid in acute porphyria. phenytoin tonic-clonic, focal, neurosurgery, severe head injury; s/e skin, blood, gum disorders

2nd line prescribing: **depends on type of seizure (see British National Formulary)**

- topiramate (men), Monotherapy/adjunctive: Focal and generalised seizures. S/e eg aggression, agitation, anxiety, depression, suicidal ideation.
- zonisamide (men) Monotherapy/adjunctive: Focal seizures +/- generalisation. S/e eg agitation, confusion, depression, insomnia, psychosis

DO NOT prescribe:

- sodium valproate, topiramate, zonisamide (women of child-bearing age)
- gabapentin, pregabalin, clonazepam, clobazam, phenobarbital high risk abuse, diversion

Emergency treatment prolonged, repeated seizures: buccal midazolam (1st line NICE); rectal diazepam if this is not available. Caution abuse potential.

Psychosis

This brief guidance provides some expansion on the corresponding chapter in Safer Prescribing in Prisons (2nd edition, 2019). It draws on national guidance.

Psychotic patients present a very high risk to themselves and to others. Their behaviour is often unpredictable. They require close and expert care and supervision.

Assessment: Screen for mental illness at first-stage health assessment. If there is a history suggestive of psychosis or prescribed antipsychotic medication, it is important for the prescribing clinician in reception to assess the person's wellbeing and to decide whether or not antipsychotic medication should be given immediately. Factors to take into account will include:

- presenting symptoms which often include agitation, delusional thinking, hallucinations, drowsiness, signs of intoxication as well as withdrawal from drugs or alcohol
- polypharmacy and the safety of continuing medication, balanced against the risks of dose omission (antipsychotics are on the list of medicines where omitted doses could be harmful in NICE physical health in prisons guidelines NG57 (2016))

- history of substance misuse.
- UDT results confirming the presence of prescribed or illicit drugs which could negatively impact on the safety of administering mental health medication
- uncertainty or lack of information about mental health diagnosis or reason for antipsychotic prescribing
- uncertainty about adherence to prescribed mental health medicines

Where psychosis is suspected, people should be referred to a mental health specialist for further assessment, collateral information gathering and diagnosis. Routine referrals will be assessed by a member of the mental health team within 5 working days and urgent referrals within 48 hours (for an individual in a mental health crisis, or with rapidly escalating needs or presentation, and/or at risk of immediate harm to self or others). If there is immediate concern about the safety of a person entering custody, an ACCT should be opened and multi-disciplinary support provided.

It is important to be aware that prison may exacerbate mental illness and trigger symptoms suggestive of psychosis, either as part of schizophrenia, hypomania or paranoid psychosis or in severe depression, anxiety disorders, behavioural disturbance or personality disorder. Illicit drug use may also present with psychotic symptoms. Regardless of the possible cause of psychosis, if it is suspected, further assessment by the mental health team should be requested.

Management:

Psychosis requires specialist management, involving individual assessment of both psychological and pharmacological treatment needs. This brief guidance covers the basic principles of prescribing and monitoring. It is aimed at assisting non-specialists in the healthcare team and does not address the complexities of management or psychological treatment options.

Prescribing in reception:

- There is no obligation for a prescriber to continue medicines initiated by another clinician where there is doubt about the diagnosis. It is good practice to evaluate all medicines that have been previously prescribed to assess whether or not there is ongoing clinical indication and to adjust treatment if considered appropriate.
- It is important, when evaluating the balance of risks and benefits to starting treatment in reception, to be aware that NICE guidelines NG57 (2016) Physical health of people in prisons includes antipsychotics on the list of medicines where omitted doses may be harmful.
- Although there is a lower risk of dependence with antipsychotic medication than with some other classes of prescribed drugs, misuse of some antipsychotics is recognised, related to sedating effects (e.g. quetiapine, olanzapine).
- **If the decision is made to continue* antipsychotic medication in reception** (*previously prescribed), a short interim script is recommended to cover the period until collateral information has been gathered, medicines reconciliation is complete and an assessment by the mental health team can be carried out. It is important to ensure prompt information sharing and gathering particularly for some antipsychotics, where the risk of harm from dose omissions is high (e.g. clozapine, lithium).
- **If a non-specialist clinician considers that antipsychotic medication may need to be initiated* in reception** (*not previously prescribed) due to concerns about the symptoms and immediate safety of a patient, **specialist mental health advice** should be sought **prior to prescribing**.

- If there is no clear clinical need for ongoing prescribing of a specific medicine but potential adverse effects from abruptly stopping it, dose tapering may be appropriate.
- **If the decision is made <u>not</u> to prescribe antipsychotic medication in reception** or until further evidence is available from medicines reconciliation or until a person has been seen by a mental health specialist, this should be documented in the patient's SystmOne records together with the reason why. The patient should be told about the decision and given reassurance that their need for the medicine is being reviewed within a clear timeframe. Regular communication is important in reducing a person's anxiety and risk of self-harm. Working in partnership with mental health nurses to support and monitor these patients is important.

Initiating new treatment for psychosis:

- Health and Justice Mental Health Services: Safer use of mental health medicines (2017) states that psychiatrists or non-medical mental health prescribers should initiate all antipsychotics and mood stabilising medicines and that patients should be involved with making treatment choices, informed of how the medication should be taken, possible side effects, and any monitoring that is required.
- In line with NICE guidance CG178 (2014), prior to starting antipsychotic medication, baseline investigations are required, including:
    - weight
    - waist circumference
    - pulse and blood pressure
    - fasting blood glucose, glycosylated haemoglobin (HbA_{1c}), blood lipid profile and prolactin levels
    - assessment of movement disorders
    - assessment of nutritional status, diet and level of physical activity.
    - ECG – depending on type of antipsychotic and any history suggestive of cardiac risk.
- Scripts should be written onto SystmOne, printed and signed by the specialist prescriber, taking into account the patient's current in-possession (IP) status and local policies for IP status of the antipsychotic prescribed. They should normally be within licenced indications and dose ranges and follow national clinical guidelines. Any variation should be clearly explained and documented on SystmOne.
- Specialist prescriber scripts should cover any supplies of medication during the titration period and until the next planned clinical review.
- A repeat template should be set up by the specialist prescriber, from which primary care prescribers can issue scripts between specialist reviews however, primary care prescribers in secure settings are advised to prescribe antipsychotic treatments only within their licensed indications.
- Each patient should have an individually tailored written care plan, including an outline of strategies to address physical and mental health needs, measurable goals and outcomes, strategies for self-management, any advanced directives, crisis and contingency plans, and review dates with a discharge framework.

Adherence:

- It is helpful if the care plan includes details of how to manage prescribing if a patient shows poor adherence to medication or is suspected of using illicit drugs alongside their antipsychotic script. Poor adherence and illicit drug use should trigger a medication review and a mental health review of the patient with multi-disciplinary team discussion and specialist advice sought.

- Email or telephone communication with a specialist prescriber may provide an effective means of achieving a safe interim prescribing plan until it is possible for a follow up face-to-face specialist clinical review.

Repeat prescribing, medication reviews and monitoring

- NICE guidance CG178 (2014) states that the mental health team should maintain responsibility for monitoring the effects of antipsychotic medication and the physical health of patients on antipsychotics for at least the first 12 months of treatment or until the person's condition has stabilised, whichever is longer.
- Safer use of mental health medicines (2017) recommends that review of treatment should be done by the mental health specialist for antipsychotics and for people with mental health care plans led by the mental health team. It also recommends a recall system with a clear time frame.
- In addition to timing of reviews being dependent on the stability of a person's mental illness, the guidance recommends variation according to whether a person is on remand or is sentenced, with a maximum of 3 months between reviews for a person on remand and 6 months for those who are sentenced.
- Recommendations state that reviews should evaluate:
    - diagnosis and whether still appropriate
    - response to treatment, including changes in symptoms and behaviour, progress as measured against patient-centred goals
    - side effects of treatment and their impact on functioning including any movement disorders developing (medication side effects and symptoms of illness may be very similar)
    - other conditions and their treatment which may impact on the safety of mental health medicines and affect overall care (e.g. OST, strong analgesia)
    - communication from prison staff and healthcare teams about behavioural concerns, medication incidents and adherence.
    - therapeutic drug monitoring
    - physical health monitoring – includes plot of weight, weekly wk 1- 6, then at wk12, at 1 year and then annually; plot waist circumference annually; pulse and blood pressure at wk12, at 1 year then annually; fasting blood glucose, HbA_{1c} and blood lipid levels at wk12, 1 year then annually; overall physical health and lifestyle
- Policies and service care delivery models developed in partnership between care providers should identify when local **shared care** arrangements may be introduced and how they will work.
- Specialist prescribing in secure environments should continue where local primary care prescribing policies or national specialised commissioning policies require this.
- Where shared care arrangements transfer the responsibility for prescribing and monitoring between specialist reviews to primary care, non-specialist prescribers should be provided with adequate information in the patient's care plan. This should include:
    - Diagnosis
    - Doses of prescribed antipsychotic medication including details of any planned dose changes and any other information needed to safely generate and sign the repeat prescription
    - Physical health monitoring required
    - Therapeutic drug monitoring where required (e.g. clozapine, lithium)
    - Date of next mental health review
    - Symptoms that should trigger contact with the mental health team earlier than the next planned review.
- Non-specialist prescribers are advised to prescribe antipsychotic treatments only within their licensed indications and recommended dose range.
- Pharmacy-led medicines use reviews (MURs), should be considered for additional patient support, particularly if a person is prescribed multiple medications.

- Responsibility for prescriptions including repeats should be documented in the patient S1 record to ensure that requests are made in a timely way to the appropriate prescriber.
- LESTER UK adaptation (2014 version) Positive cardiometabolic health resource https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis/national-audit-schizophrenia provides a framework for intervention depending on the outcome of physical monitoring in people with psychosis and schizophrenia.

Continuity of care: prescribing on release or transfer

- The principles of providing a comprehensive discharge summary with details of ongoing medicines are the same for mental health patients as for all other people being released to the community or transferred to another prison, where they will have a new care provider. RPS guidance (2012) Keeping patients safe when they transfer between care providers - Getting the medicines right, Appendix 2 provides details of required medicines information.
- A 7-day supply of medicines should be provided when a patient is being transferred to another establishment or released. This is important to avoid harm from omitted doses, particularly with antipsychotics (see NG57 (2016) list of medicines where omitted doses may be harmful.)
- If a patient is released unexpectedly from court, an FP10 can be written for a patient for seven days of treatment to be collected from the prison gate, enabling them to collect their medication from a community pharmacy. If transfer to another establishment occurs but was not expected, every effort should be made to ensure that the patient has access to an uninterrupted supply of medication.

Neurodevelopmental Disorders

Assessment: Most neurodevelopmental disorders are diagnosed in childhood. If a new diagnosis of ADHD or ASD is suspected in an adult in prison, a specialist is required to make the diagnosis and to complete a baseline assessment prior to initiating treatment. (NG87, CG142, CG128, CG170)
Baseline assessment: check co-existing mental health/other neurodevelopmental conditions; perform substance misuse/diversion risk assessment; assess physical health: check for conditions contraindicated with specific medicines (see BNF), current medication, height, weight, BP and pulse, cardiovascular assessment. If cardiac risk is detected, refer to cardiologist before starting medication. If no increased cardiac risk, an electrocardiogram (ECG) is not needed before starting stimulants, or atomoxetine.
Management:
Continuing medication from community: Confirm specialist diagnosis and medication (through medicines reconciliation process) as soon as possible to avoid disruption to treatment if a person comes in to prison with medication prescribed for ADHD or Tourette's. It is important to continue treatment in patients with established diagnoses who have been compliant with their medication. If diagnosis is uncertain or information inadequate to safely confirm ongoing treatment, specialist input will be required prior to prescribing.
Initiation of medication in prison: should only be done by a specialist and after a baseline assessment.
Adherence: Due to the risk of abuse or diversion of medication, administration under supervision is recommended. Adherence to treatment plans may be variable in people with ADHD due to their symptoms. It is helpful if the care plan includes details of how to manage prescribing if a patient shows poor adherence to medication or is suspected of using illicit drugs alongside their script (see Psychosis/adherence section).
ADHD
Pharmacological

1st line: lisdexamfetamine, methylphenidate* (*unlicensed)
2nd line: atomoxetine
3rd line: dexamfetamine* (*unlicensed) refractory ADHD; contraindicated if history substance misuse
Monitoring

- Monitor weight/BMI in adults every 6/12.
- Monitor heart rate and BP before and after each dose change and every 6 months. If tachycardia, arrhythmia or elevated BP on 2 occasions, dose should be reduced and the patient referred to adult physician.
- NG87 suggests specialist medication review with patient at least annually to discuss benefits, adverse effects and risks, impact and continuation of medication. Instability which may be triggered by the prison environment may require more frequent specialist reviews. If reviews suggest risks of treatment outweigh benefits, trial periods of stopping medication or dose reduction should be considered. If medication is continued, reasons should be documented.

Narcolepsy and cataplexy

Narcolepsy is a rare long term brain disorder that can cause excessive daytime sleepiness with or without cataplexy. Diagnosis, assessment and management should be under specialist supervision.
Assessment: Confirm specialist diagnosis and prescribing if a person comes into prison on treatment. Cardiac history should be reviewed (due to risk with specific treatments) and a history of substance misuse checked since dexamfetamine is contraindicated in this case, and other licensed treatments are at risk of abuse and diversion e.g. modafinil is popular for its alerting properties and perceived improved brain function.
Management:
Pharmacological
Modafinil, dexamfetamine* CNS stimulants; (*contraindicated if history of substance misuse)
Pitolisant H3 antagonist
sodium oxybate. CNS depressant – expert supervision only

Pain

Guidance on the management of pain can be found in NHS England Prison Pain Management Formulary, Safer Prescribing in Prisons (2nd edition, Jan 2019), Opioids Aware. There is also a brief 'Dos and Don'ts' resource on using the Prison Pain Formulary, available in the RCGP Healthcare in Secure Environments Toolkit.
Assessment: It is important to be aware that in secure settings, the presentation of persistent pain is often very complex and may differ from the community setting. People may have a history of multiple injuries, several underlying potential causes and maintaining factors together with substance misuse and mental health comorbidities. Multi-disciplinary collaboration is essential for complex cases of persistent pain. Some patients may require referral for further investigations and injections/nerve blocks.
Management:
Non-pharmacological: non-pharmacological interventions, tailored to the individual, are important in the management of persistent pain and neuropathic pain. A multi-modal approach, addressing both the psychological and physical aspects of persistent pain is required. It may be possible to address the psychology of pain through group sessions and providing education about pain and coping mechanisms but in more complex cases, 1:1 interventions may be needed. Physiotherapy, TENs machines and acupuncture are among physical treatments.
Pharmacological:
Acute and persistent pain
Simple analgesics and NSAIDs:

1st line: paracetamol ensure max dose before escalating analgesia; NSAIDs: ibuprofen, naproxen lowest dose, shortest time; co-prescribe NSAIDs/paracetamol before escalating
2nd line: Cox2 inhibitors/other NSAIDs (in line with CCG formulary); Topical analgesics: ibuprofen, piroxicam, algesal (caution: systemic effects with large amounts)
AVOID diclofenac, nefopam, topical rubefacients

Opioid analgesics: limited efficacy in persistent pain; risk of dependence; risk of respiratory depression and death, particularly at high doses and in combination with gabapentinoids or other CNS depressants; use only when simple analgesia and non-pharmacological management has failed. Use long acting preparations. Avoid doses 120mg morphine/equivalent. Risk of abuse and diversion, may be requested to mask illicit opioid use; supervised consumption and compliance checks recommended.
Codeine, co-codamol, DHC*, tramadol*, morphine* (*long acting preparations in persistent pain) Avoid co-prescribing tramadol and SSRI/SNRI – risk serotonin syndrome.
AVOID oxycodone, methadone (except for emerging pain when substance misuse tapering), transdermal opioid patches, fasting acting opioid preparations

Neuropathic pain

Fewer than a third of patients will respond to any given drug. Discontinue ineffective drug.
1st line: duloxetine, amitriptyline (risk diversion, abuse, death in overdose; cardiac risk - ECG if other QTc prolonging drugs), carbamazepine (1st line in trigeminal neuralgia),
4th line: tramadol (refractory neuropathic pain confirmed origin only; avoid with SSRI/SNRI)
AVOID nortriptyline (not cost effective, exceptional cases only),
AVOID gabapentinoids (high risk abuse and diversion; avoid initiation; review/reduce and stop in patients at risk from their prescribing or substance misuse or where no ongoing licensed clinical indication. Assisted withdrawal regime: reduce by up to 50–100mg/week pregabalin or 300mg every 4 days gabapentin)
AVOID transdermal opioids, lidocaine patches (specialist use only)

Palliative Care

Prisons should provide compassionate and holistic palliative care, meeting the needs of patients with additional specialist community and third sector input. Palliative care medicines are potent and can be misused therefore good medicines governance is important to ensure their safe and effective use in prisons. Prescribing guidance may be sought from specialist palliative care colleagues. Marie Curie and RCGP have collaborated to create the Daffodil Standards and further guidance can be found in the RCGP Palliative and End of Life Care Toolkit
https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/palliative-and-end-of-life-care-toolkit.aspx

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RCGP Palliative and End of Life Care Toolkit
https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/palliative-and-end-of-life-care-toolkit.aspx

The Daffodil Standards: UK General Practice Core Standards for Advanced Serious Illness and End of Life Care. https://www.rcgp.org.uk/daffodilstandards