Royal Pharmaceutical Society
of Great Britain

Helping pharmacists achieve excellence

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Dear Dr Piper,

Re: Clinical Management of Drug Dependence in the Prisons Setting

I write on behalf of the Royal Pharmaceutical Society of Great Britain to respond to the above consultation document.

Whilst it is recognised that significant changes are now taking place within the prison service, there remain identified concerns relating to the following issues:

Assessment on arrival (Sections 3 & 13)
The document states that the clinical assessment following reception should include a full drug use history, including past and current injecting (with inspection of injection sites and abscesses) and details of current community treatment. The Society has concerns regarding the risk assessment process and who conducts it and would suggest that the process should be undertaken by an on-site doctor / pharmacist. The Society also has concerns at the time delays that ensure the initial assessment.

Observations (Sections 2.1/3.5/4.1/9.1)
The document discusses observation of inmates via 'open health care hatches where these have been installed. (HMPS 2000, Prison Service Order 3550)' but does not provide any guidance on what should be done if a healthcare hatch has not been fitted. This anomaly needs to be addressed.

Education and training
The document does not address who takes responsibility for training (ie prison versus Primary Care Organisation). Education and training in substance misuse for healthcare professionals and other staff working in prisons is essential if standards of care are to be improved.

Substance misuse is by far the biggest health problem in prisons and it will not be tackled effectively unless all staff are adequately prepared. Different members of the multi-disciplinary teams involved in care have different training needs. Education and training must also be extended to prison officers because they play an essential role in supporting care and rehabilitation.

Training recommendations have been made in previous ACMD reports 'Treatment, Rehabilitation and Prevention'. However, training still appears to be variable in extent, quantity and quality.

In addition, there appears to be some confusion in the document with respect to alcohol/drug misuse detoxification.

Stabilisation/dosage (Section 4.3)
Under sub-section 1, continuing treatment on release must not be assumed. Prisoners often find it difficult to gain access to community based services after release. This puts them at particular risk of relapsing into illicit drug use and suffering overdose. Assuring continuity of care is often difficult as there are several barriers to overcome. It is an area that demands particular attention.

Under sub-section 6, the words 'at least' should be inserted before 200 mls, otherwise staff will feel they have to measure an exact quantity.

The next paragraph (p13) suggests initiation of methadone treatment through the process of dose induction. While this may reduce any potential risk of overdose it is unlikely to be practical in a prison setting.

In the third paragraph (p13) the maximum recommended maintenance dose of methadone is set at 40 mgs per day. This is unnecessarily conservative and will be inadequate to treat effectively many opiate misusers. It is intended to reduce the risk of overdose but is likely to subject the patient to the greater risk of illicit drug use in the prison. The Guidelines introduced by the Scottish Prison Service in 1998 specified a maximum dose of 60 mgs per day but this was removed in 2001 because it prevented adequate treatment of many patients, including those who had been prescribed a higher dose as part of a Drug Treatment and Testing Order.

In the fourth paragraph (p13) it is proposed that where doses are allowed to exceed 40 mgs this should be administered in divided doses. As patients in this category will have received singly daily doses previously it is not clear why this recommendation is necessary.

Continuation of methadone programmes (Section 6.2)
Under the heading 'next day (day 2)' it is stated that the pharmacist should confirm name and date of birth of the patient and should provide a brief description of the patient. There needs to be recognition of the confidentiality issues involved in such an exchange of information. The prisoner will need to consent to the pharmacist being contacted and the pharmacist will need to be assured that consent has been given for information to be provided.

Nursing observation / withholding medication (Section 9.2)
This section proposes that nurses must withhold methadone and other sedating medication if they suspect additional illicit drug use. It is important to emphasise that withholding treatment should not be used to punish prisoners but should only take place when there are clear clinical grounds for doing so. The word 'clean' used at the bottom of page 25 requires clear definition.

Continuity of treatment (Section 15)
There is no clear tie-up between the information and care provided in prisons and within the community setting. Ensuring continuity of information and care across the prison and community boundaries would reduce the likelihood of individuals being discharged without appropriate medication.

The Society has concerns that developing a fragmented care pathway for what is a high need client group (immediately post prison release) is inviting long term problems for local services.

As well as the instances listed in the heading (leaving custody, attending court or transferring to another prison), it is also important to provide treatment during periods of home leave. Paragraph 15.2 proposes that a community pharmacist should be allocated to provide an interim dispensing service when a prisoner is released on a Friday. This may not always be easily achieved and could require considerable organisation. This is particularly the case when a prisoner is returning to a location far from the prison.

There are also important issues of patient identification, payment for dispensing, and payment for supervision, particularly if non-NHS prescriptions are used. The alternative suggestion of providing a maximum 3 days supply for the prisoner on release carries a very high risk of overdose or diversion.

Sterilisation of injecting equipment (Section 19.2)
The provision of disinfecting tablets for the sterilisation of injecting equipment is relatively easy and inexpensive. It would be helpful to give this a higher priority.

Consent and confidentiality (Sections 20.2 & 20.3)
Guidance on confidentiality in relation to children seems unnecessary as the guidance is specifically for those aged 18 and over.

Criminal Justice System
A class action lawsuit is being taken against the prison service by individuals who were made on discharge to be part of some type of detoxification programme. In light of this, it would be useful to include advice in the document on the boundaries of what is deemed to be acceptable.

Needle exchange schemes
Needle exchange schemes are not applicable in prisons in England and Wales but do apply in Scottish prisons.

Inspection of prisons
Clarification is needed on who will take responsibility for inspection of prison facilities. If this is assigned to primary care, then it is important to assure that individuals have the requisite skills and training needed to undertake this role.

CARATS
Clarification is needed on how far the drug intervention plan will link in with CARAT services. Although CARAT have very good links within prisons and outside agencies (Throughcare) they do not link in with primary care services (GPs etc).

Disposal of patient returns / waste disposal
The document needs to address the issue of disposal of patient returns and waste disposal in prison settings (there may be a risk of diversion of Controlled Drugs etc).

3 year implementation plan / costs
Three years appears to be a long timeframe for implementation of the plan.

It is not clear whether the guidance will require substantial resource but this is likely to be the case. Introduction of the guidance must be adequately resourced both to ensure effective implementation and to prevent diversion of resources from other aspects of health care.

Evaluation
It is important that implementation of the guidance is properly evaluated to measure performance and to identify areas for revision.

The ACMD has previously discussed issues relating to Controlled Drugs in prisons and has published reports relating to this subject. The overall aim should be to establish the same kind of policies regarding good evidence-based care as exist in primary care and community care and patient benefit should be the driving force. Assuming the intention of the guidance is to raise and generalise standards of treatment for substance misuse, it would be helpful if the document emphasised the benefits of such treatment and the importance of maintaining continuity between prison and community.

The Society cannot currently endorse the document as it stands, but in order to move this agenda forward would like to arrange a meeting with a representative from Prison Health to discuss in further detail the use of Controlled Drugs within prisons.

Please note that many of the comments made in this response will also apply to the 'Young people in secure environments' document.

I hope the feedback provided is useful.

Thank you for your assistance.

Yours sincerely,

Sadia Khan (Miss)
Practice Pharmacist – Lead for Self-care