An evaluation of in-possession medication procedures within prisons in England and Wales

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Introduction

Offenders often come from deprived backgrounds with histories of social exclusion and disadvantage, frequently compounded by complex and multiple health problems. Since the clinical development partnership between the NHS and HM Prison Service was instigated in 1999, a wide ranging work programme has been undertaken to improve prison based health services to improve people’s health and life chances. Much of this has been driven by the ‘equivalence principle’, the notion that prisoners should have access to ‘the same quality and range of health care services as the general public receives from the NHS’ (Health Advisory Committee for the Prison Service, 1997).

Every year, approximately £7,000,000 is spent on medicines for prisoners (DH, 2003). Historically, healthcare staff have been responsible for supervising and administering single doses of all but the most benign of medications. However, the drive for equivalence of care has led towards allowing in-possession medication to become the default position, rather than the exception. In-possession medication means that where possible, prisoners are given autonomy and responsibility for the storage and administration of their medication, dependent on individual risk assessment (Bradley, 2007).

Notably, several benefits of in-possession medication have been previously reported including medicines being administered at more appropriate times, reductions in time spent by prisoners queuing at medication hatches and reductions in workload for healthcare staff and escorting officers (DH, 2003). Despite such evidence, there apparently remains unease among some staff working within prisons based on notions that in-possession medication may increase the risk of drugs being abused, traded, stolen or used to self-harm via overdose (Bradley, 2007).

This study was commissioned by Offender Health at the Department of Health to establish current practice and policies in relation to in-possession medication currently in operation within prisons in England and Wales.
**Aims**

The main aims of this study were:

- To determine current policies and practices in relation to in-possession medication across the prison estate in England and Wales;
- To explore the views of key stakeholders, including prisoners and staff, regarding the perceived barriers and benefits of in-possession medication, and suggestions for improving practice; and
- To identify examples of good practice and make recommendations about how in-possession medication policies and practices might best be taken forward across the prison estate.

**Methods**

The study adopted a mixed-methods approach incorporating both qualitative and quantitative data. Data collection was divided into two distinct phases:

**Phase 1** - A national survey of all prison establishments in England and Wales to establish current practices in relation to in-possession medication procedures.

**Phase 2** - Semi-structured interviews in 12 prisons to elicit professional and service user perspectives on in-possession medication.

**Results**

**Questionnaire survey key findings**

- A 90% response rate was achieved. Of those that responded, all reported to have in-possession medication operating within their establishments to some degree.
- Fewer than half of all prisons (42%) had a written policy relating to the verification and prescription of medication for newly received prisoners. However most prisons (78%) reported that they did aim to verify prescriptions within three days of reception into custody.
- Healthcare staff were the main contributors to the development of in-possession medication policies.
- While the majority of in-possession medication policies included sections on risk assessment and monitoring/review (87% and 71%), fewer detailed security arrangements surrounding in-possession medication and storage (29% and 24% respectively).
- Most establishments (93%) used a structured risk assessment method for assessing suitability for in-possession medication. However, these varied in
terms of structure and the types of risk factors assessed. The vast majority (96%) specifically considered risk of suicide/self-harm.

- The main prompts for review of in-possession medication were clinical factors and/or changes to a patient’s condition or their environment. Two establishments (both open prisons) reported that they never reviewed in-possession medication.
- Just under half of establishments (44%) reported that they provided specific storage facilities for in-possession medication. Local prisons and young offender institutions were the least likely to provide storage facilities (20% and 29% respectively).
- Since 2003, there has been an increase in the number of prisons that reported having a drug and therapeutic committee and in the number that used limited prescribing lists. There had also been changes in the types of pharmacy providers used, with decreased use of satellite prison pharmacies and increased use of independent providers.

**Semi-structured interviews**

The key findings from this section of the results can be summarised as follows.

- The process of verifying medication was seen to be complicated by several factors including external factors, prisoner factors and establishment factors.
- Respondents argued in favour of a national/regional database which would allow information on a prisoner’s health and prescribed medication to be accessed directly.
- Respondents reported the value of prison staff fostering stronger links with community healthcare providers or pharmacists.
- Respondents stated that prisoners should be received from a smaller catchment area to improve communication with local primary care and pharmacy services.
- Respondents’ personal experiences of the operation of in-possession medication at their establishment were generally positive.
- Establishments varied according to when people were risk assessed; some conducted the assessment at reception and others waited until the prisoner had been assessed by a doctor.
- Little consistency between establishments was found regarding which staff were responsible for the risk assessment process.
- The majority of pharmacists interviewed had somewhat negative perceptions of current risk assessment processes. Generally, they expressed a view that risk was dynamic and that existing assessment processes did not reflect this.
• Respondents stated that risk assessment forms in current usage were outdated and not reflective of current prescribing practices.

• There were concerns about the robustness of the risk assessment process; respondents commented that it was insufficiently thorough or unduly influenced by subjective staff opinion.

• Staff respondents stated that it was common practice for prisoners to sign a contract/compact promising not to trade or otherwise misuse their medication before in-possession was sanctioned. However, prisoner respondents frequently commented that they were unaware of the details or implications of such contracts.

• Monitoring of in-possession medication was frequently viewed as a collaborative process, involving security staff and the various clinical professions.

• Prisoners stated that the convenience of having in-possession medication increased the likelihood of them remaining concordant with treatment regimes.

• Barriers to in-possession policies included staff attitudes; prisoner attitudes, system difficulties and the prison environment.

**Recommendations**

• Supplying medication in-possession should be the default position in prisoners; justification should be required for opting out of this policy, rather than justification for opting in.

• Healthcare teams within prisons should be aware of the opening hours of local healthcare providers, ensuring that they exploit fully those providers which do remain open after 5pm on weekdays.

• Busy local prisons should serve as small a local catchment area as possible to facilitate information exchange with local healthcare providers.

• Verifying medication should be a routine task following reception into custody, undertaken by discretely tasked staff.

• Consideration should be given to an information campaign – for example circulating information leaflets to local GP practices and other community healthcare providers – to explain the role of prison healthcare teams and their status within the NHS.

• Medication education should be routinely offered to prisoners provided by the multi-disciplinary healthcare team.

• Clinical IT systems within and outwith prisons should be shared, allowing access to comprehensive patient information whether people are in or out of custody.

• All prisons should be covered by a Drug and Therapeutics Committee or equivalent.
• Medicines, as a matter of principle, should be held in the possession of prisoners.

• Each prison establishment should have an in-possession risk assessment policy developed and ratified by the Drug and Therapeutics Committee, for determining, on an individual basis, any exceptions to the default possession of medicines and related devices being held in-possession.

• The development and implementation of a nationally ratified, evidence-based, structured professional judgement risk assessment instrument should be considered to reduce inconsistencies in risk assessment processes. Assessment should be undertaken at a defined point after reception, followed by a dynamic review process when clinical, patient or environmental changes occur.

• All cells should have some form of lockable storage for medication.

• All prisons should have a system of recording adverse events.

• Sufficient supplies of medicines should be issued to prisoners to cover the whole period they are in court or being transferred between establishments.

• A policy of in-possession and risk assessment criteria, developed through the drug and therapeutics committee, and implemented in co-operation with prisoner escort services, should extend to those prisoners attending court or on transfer.
1. Introduction

1.1 Background

The prevalence of physical and mental health problems is higher in prisons than in the general population. In a sample of adult male prisoners, 46% reported having some type of long standing illness or disability (Bridgwood & Malbon, 1995). Specifically, 10% of prisoners reported asthma, bronchitis or other respiratory problems and 15% of prisoners aged over 45 reported having a heart or circulatory illness (ibid).

Plugge et al (2006) reported particularly high prevalence of physical ill health for adult women in remand prisons, with 83% reporting a longstanding illness or disability compared with 32% of the females in the general population. The most common illnesses cited included depression (57%) and anxiety and/or panic attacks (42%). Sexual health problems are common among prisoners; one self-report study found that 22% of prisoners reported having had a sexually transmitted infection at some time in their life (Green et al, 2003). Rates of mental illness are also noted to be particularly high in prisons, with 90% of all prisoners having a diagnosable mental health problem, personality disorder and/or substance misuse problem (Singleton et al, 1998).

Since 1999, the NHS and HM Prison Service have been engaged in a clinical improvement partnership based on the broad principle that prisoners should have access to healthcare services of equivalent scope and quality as are available to the wider population. In terms of the current report, application of the principle of equivalence has contributed to developments in practices around ‘in-possession’ (IP) medication meaning that, when safe and appropriate, prisoner-patients should be given autonomy and responsibility for the storage and administration of their own medication. This contrasts with earlier routine practice whereby medication was generally only given in single, supervised doses (Bradley, 2007).

The aim of this report is to evaluate current practices around the operation of in-possession medication policies within prisons in England and Wales, and to examine potential ways of ensuring the widest acceptability, safety and efficacy of in-possession medication practices through the adoption of proven community-based strategies, appropriately and proportionally adapted to take into account the discrete security and institutional influences operational within prisons.
1.2 In-possession medication in community and hospital settings

In-possession prescription medication in the community is common practice for both acute and chronic conditions, supplemented by the wide availability of non-prescription medication for minor ailments. However, the ability to self administer medication is not universal; for example some hospital wards do not allow in-patients to retain supplies of medication. In such cases even the most competent of patients who manage medication effectively at home may have it taken from them once in hospital and not returned until they are discharged (Dimond, 2004).

Traditional practice on in-patient wards involved the administration of drugs by nursing staff at set times throughout the day. Several problems have been identified with such drug rounds including issues with administering medicines at set times (Cousins, 1992; Gaze, 1992); patients becoming dependent on staff to receive medicines (Hassal, 1991); and a lack of education or advice on managing conditions upon discharge (Turton & Wilson, 1981).

Such care systems potentially create patient “learned helplessness”, leading to a loss of skills relating to self care in general and medication management in particular (Dimond, 2004). They are also at odds with expectations outlined in the NHS Plan, NMC Guidelines for the Administration of Medicines and Improving Health in Wales (NHS, 2000; NMC, 2002; NHS Cymru Wales, 2001). These documents collectively agree that patients should be involved in decisions around the prescription of medication; be responsible for self-administration; be educated in matters relating to medication; and take personal responsibility for its use.

Patients self administering medication within hospital environments has been reported to provide several benefits including patients retaining control over medicine; patients having the opportunity to practice taking medication under supervision; healthcare staff being able to observe problems with adherence to medication regimes; improvements in patient morale; increased patient comfort in relation to pain relief and sleep (HCC, 2003); improved communication between nurses and patients (Wade & Bowling, 1986); and improved adherence to drug regimes upon discharge (Baxendale et al, 1978; Bird, 1988; Webb et al, 1990). Furlong (1996) reported that 86% of their sample of hospital ward patients preferred to keep control over their medication whilst in hospital. In a review of twelve empirical studies evaluating self-administration of medication, Collingsworth et al (1997) reported that the most commonly reported disadvantage of patients retaining control of their medication in hospital settings was under, rather than over, administration. No studies reported incidents regarding problems surrounding maintaining security of patients’ medication, for example patients stealing medication.

The majority of self-administration policies within hospital settings outline assessment stages for patients being considered for self-administration as an in-patient. The example below typifies the general content of self-administration policies in operation across NHS Trusts. Such policies allow patients to retain
control over the administration of medication, depending upon satisfactory assessment of their level of competence.

- **Stage 1** – One week’s supply of medication is supplied to the ward in containers containing patient directions on the label. Medicine is kept in the trolley to be self-administered in the presence of nursing staff.

- **Stage 2** - Individual day supplies sent to the ward in medication bags or another form of packaging designed to aid compliance and issued to the patient.

- **Stage 3** – Two bags are supplied by pharmacy to be given to the patient, one with three days’ supply and the other with four days’ supply.

- **Stage 4** – Weekly supplies are issued to the patient.

  (Bolton, Salford, and Trafford Mental Health NHS Trust, 2006).

The provision of drug information leaflets is an important aspect of self administration, in compliance with European Council Directive 92/27/EEC of 31 March 1992 on the Labelling of Medicinal Products for Human Use and on Package Leaflets (EEC, 1992). This stated that all medicines supplied to patients should be labelled with a batch number and expiry date and be supplied with an information leaflet explaining the medication’s use and risks in lay terms, in the appropriate language. This would require consideration to be given to patients who have trouble reading labels and therefore may have issues following directions. In such circumstances alternatives such as the use of symbols (e.g. moon and sun to indicate administration times) or colour codes along with verbal instruction on use of the medication should be employed, rather than simply using the difficulty as an exclusion criterion (HCC, 2003).

### 1.3 Wider medicines management and clinical governance issues encompassing prison settings

It is recommended in the document *A Pharmacy Service for Prisoners* (DH, 2003) that NHS medicine management systems should be duplicated within the prison system, requiring the development of medicine management protocols covering a range of issues including:

- The prescription, supply and administration of medication adhering with policies/protocols which ensure good professional practice;

- Non-medical prescribing;

- Repeat prescribing;

- Repeat dispensing;

- Management of chronic conditions and protocols for timely reviews of associated medication;

- Return and disposal of unwanted or unused medication;

- Establishment-wide formularies;
• Procedures for accessing supplies out of hours;
• Procedures for identifying and reporting adverse incidents and drug reactions;
• Policies for the supply of non-prescription medicines, through either healthcare departments and/or prisoners’ shops; and
• Accurate clinical record keeping and developments in clinical information technology.

Evaluating how effective medicine management systems operate is an essential part of NHS clinical governance systems which seek to maintain or improve standards through examining service quality, risk management and the monitoring of new initiatives (DH, 1999). Such clinical governance procedures apply equally to healthcare services operating within prisons. Clinical audit is a fundamental part of clinical governance, evaluating actual service delivery against pre-defined expectations of quality contained within clinical policies. Similarly, systems to record and learn from adverse incidents are essential to improve patient and institutional safety.

To help deliver appropriate governance, it is recommended that all prison establishments have a drug and therapeutic committee (DTC; DH, 2003). These committees should be multi-disciplinary with members providing specialist expertise from various backgrounds e.g. medicine, pharmacy, and security. The main role of these committees is to develop local policies and procedures around medication and prescribing (NPC, 2005). Other responsibilities may include the development of in-possession formularies; reviewing medications’ overall suitability for in-possession; production of medication-specific disease management guidelines; the introduction of new medications; general prescribing policies; and developing risk assessment criteria to assess individual suitability for in-possession medication (ibid). The National Prescribing Centre (NPC) outlined the individuals that should be involved in the development of prison-based in-possession policies, including:

• Pharmacists and pharmacy technicians;
• GPs, senior medical officers;
• Healthcare managers/heads of healthcare, senior nurses;
• Non-medical prescribers;
• Governors;
• Prison officers/ Prison Officers Association;
• Special search team representative;
• Independent Monitoring Board;
• Wing managers;
• Mental health team leaders;
• Service users;
• PCT clinical governance leads;
• PCT pharmaceutical/prescribing advisers; and
• PCT primary care development managers.

Drug and therapeutic committees are also responsible for ensuring adherence to Prison Service Order 3550 Clinical Services for Substance Misusers. This states that ‘administration and consumption of controlled drugs and other drugs subject to misuse within the prison must be directly observed’ (HMPS, 2000), thus removing such drugs from any consideration of in-possession administration. Drugs with the highest potential for misuse are likely to have a high currency value in terms of illicit trading by prisoners, therefore the security implications of providing them to patients in-possession is generally agreed to be too great (NPC, 2005).

1.4 Rationale for in-possession medication in the prison setting

Within prison establishments, the administration of medication may require a patient to be escorted to the healthcare centre, wait or queue by a medication hatch or gated clinic, explain the need for their medication, wait for verification that this is acceptable and have a single dose issued by healthcare staff (DH, 2003). Several problems have been identified with such procedures, including:

• Nurses spending large amounts of time preparing and administering prescribed drug regimens when their skills could be better employed in other areas;
• Healthcare staff administering medications to large populations of often unfamiliar individuals leading to the risk of drug administration errors;
• Fixed administration times limiting the ability to administer medication at optimum times, for example with food, or at night;
• A lack of in-possession medication results in an absence of standardised risk assessment;
• Frequent changes to prisoners’ locations, resulting in administrative problems;
• Patients being moved around the prison estate, potentially resulting in interruptions to the supply of medication or medication being lost or mislaid;
• Single dose administration creates a culture of dependence likely to cause problems when the prisoner is released back into the community; and
• Time consuming procedures involved in single dose administration can interrupt prisoners’ engagement in educational and vocational activities (DH, 2003; NPC, 2005).

The rationale behind developing and implementing in-possession medication procedures within prison settings centres around an assumption that patients in prison should be treated as responsible people and be empowered to take an active
role in their own care (DH, 2003). Policies for in-possession medication should be based on an assumption that prisoners suffering from long term conditions are likely to have an understanding of how to manage their own health problems and understand the implications of self-administrating medication (South Staffordshire PCT, 2007).

However, prison environments engender inherent tensions between maintaining the security of the institution as a whole, and encouraging individuals to accept responsibility for their lives and choices. This is highlighted by the issue of in-possession medication which, anecdotally, creates feelings of unease in staff stemming from fears that medicines will be abused, traded, stolen or used to self-harm/commit suicide through overdose (Bradley, 2007; Simpson & Shah, 2006). However, it has been reported that, at a time when over 90% of prisons operated in possession medication procedures, proportionally few incidents of self-harm were a result of prisoners poisoning themselves with their own, or someone else’s, medication (Adeniji, 2003).

The potential benefits of employing in-possession systems within prison settings include:

- Prisoners taking an active role in managing their own care;
- Medicines being administered at appropriate times;
- Increased information for prisoners about their health problems;
- Improved and more equitable relations between prisoners and staff;
- Increased co-operation between healthcare staff and prisoners;
- Improved health outcomes;
- Time reductions in waiting for medications at treatment intervals; and
- Reducing the chances of missing medication upon transfer, when at court etc.

Queuing for medication during treatment intervals several times a day can also be a daunting experience for some patients, perhaps particularly the old and frail who may fear details of the medication they receive becoming known to possibly predatory prisoners (NPC, 2005). Supplying medication in-possession can tackle this, increase confidentiality and reduce opportunities for bullying. Following release, better health outcomes may be obtained if people have practised the skills and discipline of concordance with treatment whilst in prison (NPC, 2005; Pike, 2005).

It is not only patients who benefit from the implementation of in-possession medication policies within prisons; healthcare staff can also improve working practices, for example:

- Minimising the time and staffing required to administer individual doses at set times;
- Developing more efficient systems for the supply of medications;
- Increased meaningful contact with patients;
• Improved medicine management systems;
• Increased job satisfaction; and
• Safer administration of medication (NPC, 2005).

Changes in time commitments provides an opportunity to redeploy resources and for staff to make better use of their skills or enhance their training. This could include time spent on activities such as reviewing patient medications, health promotion and/or gaining new skills in supplementary prescribing and managing minor conditions (ibid).

Another benefit in-possession policies may bring is a change to prison culture through reducing the perceived value of medication. Prisoners generally regard medication as having a high potential trading value, largely due to a belief that all medication provides elation, pleasure and bestows status. However, if it is commonly understood that in-possession medicines are inherently not of abuse value, this may improve prisoners’ overall approach to, and knowledge of, medication (DH, 2003). Furthermore, by improving patients’ understanding of how medication works and what role it plays in treating conditions, it may be possible to reduce or prevent cases whereby medications are stolen, traded or hoarded (NPC, 2005).

1.5 Prison based in-possession medication policies

Numerous guidelines and policy documents have been produced both within the prison system and by other organisations around the need to empower patients to take an active role in their own care. This was a key theme outlined in The NHS Plan (NHS, 2000) and, in 2003, was adopted by HM Prison Service as the principle objective for the document A Pharmacy Service for Prisoners, which highlighted the need to provide a more patient-focused primary care pharmacy service centred on identified needs and promoting self care (DH, 2003).

It is currently recommended that, within prisons, medication and any accompanying administration or monitoring device should normally be held in-possession as a matter of principle (Bradley, 2007). Furthermore, prisons are directed toward implementing systems for the modernisation of pharmacy services by setting a number of goals and objectives including:

• Identifying individual and collective patient need to assist development of more patient-focused services;
• Improving access to pharmacy services for prisoners;
• Developing pharmacy services which encourage and support patient self-care;
• Establishing efficient delivery service systems for the supply of medicines;
• Integrating prison-based pharmacy services into other healthcare services;
• Minor ailment and medication advice clinics provided through pharmacy services;
• Providing telephone advice by pharmacists;
• Provision of clinics covering a range of topics e.g. smoking cessation, asthma, diabetes etc;
• Supporting other healthcare staff in their roles and duties;
• Effectively utilising staff resources and medicines to promote cost effectiveness; and
• Developing and improving services through clinical governance (DH, 2003).

The document *Medication in-possession: a guide to improving practice in secure environments*, produced by the National Prescribing Centre in 2005, explored the recommendations and principles of in-possession medication detailed in *A Pharmacy Service for Prisoners*, examining the benefits for prisoners and staff (Pike, 2005). Furthermore, it discussed the practical issues to be considered when developing and implementing a local in-possession policy whilst also setting primary objectives outlined as:

• Support for local prison/PCT partnerships in moving to a position whereby it becomes the norm for patients located within prisons to possess and use their own medication;
• The promotion and dissemination of good practice around medication management; and
• The standardisation of approach towards in-possession medication across the prison sector, acknowledging that each will be starting from a different baseline and use different methods to implement in-possession medication that may be appropriate to the local setting (Pike, 2005).

This report also recommended that in-possession medication policies and risk assessment criteria apply to patients being transferred to other establishments or otherwise under escort e.g. to court or police interviews (DH, 2003).

Guidelines for in-possession medication were also outlined in the 2008 document *Expectations: Criteria for assessing the conditions in prisons and the treatment of prisoners* produced by Her Majesty’s Inspectorate of Prisons (HMCIP). This document outlined the particular standards against which HMCIP measures everyday aspects of a prisoner’s life, including health and pharmacy services. Specifically with regards to in-possession medication, it noted that prison healthcare departments should provide community based services on the wings for those suffering from chronic mental and physical conditions to promote independence (*ibid*). The policies discussed also cover the important issues of the safe packaging and storage of medication.

### 1.6 Risk assessments & reviews of medication

All activities within prisons are routinely subject to risk assessment and management, with varying degrees of formality. The National Prescribing Centre (2005) list a number of factors to be taken into consideration when developing a risk assessment tool for determining an individual’s suitability for in-possession medication. These factors can be grouped into three main categories, relating to patient, clinical and environmental factors (Box 1).
Currently within prison healthcare practice, there is no national, validated risk assessment tool for in-possession medication. Rather, it has been advised that each prison should develop its own tool, taking into account specific issues at that particular establishment (NPC, 2005). For example, in local prisons with high levels of transfer activity, patients may be less settled and less well known to staff, thus local risk management needs to specifically consider these factors (Pike, 2005). Risk assessment procedures should formalise circumstances which trigger review, for example failure to attend a clinic, proposed or imminent transfer or a potentially destabilising change in legal status (NPC, 2005).

### Box 1: Factors to be considered for risk assessment tools

**Patient-related factors**
- Willingness to take responsibility for own medications
- Cognitive ability to understand medical condition and medication
- Age, e.g. children & young people
- Risk of self-harm, taking into account past behaviour and known current circumstances — such as those prisoners currently being managed as at specific risk
- History of drug misuse
- History of trading/hoarding
- Vulnerability to violence/bullying
- History or tendency to violence/bullying
- Antisocial, explosive or impulsive personality traits
- Prisoner status or change in status, e.g. sentenced/remand

**Clinical and medication-related factors**
- Choice of medication, e.g. tricyclic anti-depressant or selective serotonin re-uptake inhibitor
- Flammability of preparation and potential for its misuse
- Potential for harm from excess or missed doses
- Stability of medical condition
- Monitoring requirements
- Concordance/compliance with previous treatments
- Duration of treatment required, i.e. acute or chronic need
- Frequency of administration, i.e. as required use or regular dosing
- Access to over-the-counter medicines, i.e. from canteen list
- Suitability of medication to be stored in a cell environment
- Suitability of medication packaging, e.g. glass"

NPC (2005), p36-7

The type of medication being prescribed is also highlighted as an important factor when assessing risk; some medicines have higher toxicity and therefore either cannot be given in-possession, or only with caution. Prisons have, therefore, routinely developed local formularies that detail the types of medication that can and cannot be supplied in-possession.
Risk assessments also need to take into account the length of supply permitted. Hirst (2004) identified four broad categories for outcomes of prison-based medication in-possession risk assessment processes:

1. Not in IP;
2. IP, no more than seven days supply;
3. IP, no more than 14 days supply; and
4. IP, no more than 28 days supply.

In addition to individual patient variables, length of supply is also influenced by prison factors. Given that local prisons have high population turnover, there is greater potential for wastage of medicines. Therefore, local prisons routinely initially assess patients for seven days in-possession medication within their first week in custody (ibid). Following this, length of supply may be extended for up to 28 days. However, training prisons, with generally stable populations, usually assess prisoners for 28 days in-possession within their first week (ibid).

Once a decision regarding in-possession medication has been reached, steps should be taken to ensure that all parties involved, including the patient, understand their roles and responsibilities (NPC, 2005). As part of this process, patient information leaflets and any other relevant information, such as specific medication and/or dosing instructions, should be made available. These should take into account any language or literacy difficulties (NPC, 2005). Any concerns the patient may have about holding medication in possession should be addressed as part of the decision making process and informed consent. Prisoners are often required to sign a contract/compact outlining their understanding and agreement with their responsibilities in the process. Such compacts routinely contain clauses outlining the consequences of non-compliance, such as disciplinary action or the withdrawal of in-possession medication (Simpson, 2005). Expectations of prisoners generally cover the following areas:

- Ensuring that medication is taken only as directed by healthcare staff;
- Individual responsibility for correct storage of medication;
- The return of unused medication to healthcare staff; and
- A ban on trading or selling medication (ibid).

Obtaining informed compliance with compacts from juvenile or young offenders and those with serious mental illness or learning disabilities requires special consideration. Those aged over 16 years are, in the majority of cases, deemed competent to consent to treatment. Legal precedent dictates that young people under the age of 16 are deemed competent to consent to treatment or particular interventions if they demonstrate a sufficient understanding of the medical care that is advised (NPC, 2005). This capacity to consent requires assessment and is similar for patients with learning difficulties (DH, 2001).

The NPC (2005) stated that risk assessment tools only act to guide decision-making rather than straightforwardly determining final outcomes. A multi-disciplinary approach to risk assessment is advised, requiring the consideration of the opinions of all involved in the care and custody of the individual as one group.
of staff may have access to pertinent information not generally available to other workers.

It is also noted that any risk assessment tool only provides an assessment at a particular point in time; therefore it is important that criteria are identified for the circumstances when it is necessary to review medication or to repeat risk assessments (Hirst, 2004). The assessment of risk should be an ongoing process; an event such as bad news for a patient could increase risk, therefore it may be that it is no longer considered safe for the individual to be responsible for their medication (Pike, 2005). Furthermore it has been recommended that risk assessments are tailored to the individual and that a “one size fits all” approach is inadvisable (Bradley, 2007). Along with formal risk assessment procedures, regular clinical review, defined as a structured, critical examination of patients’ medications, are essential to good practice with regards to in-possession medication (NPC, 2002).

Different approaches and levels to performing medication reviews have been described including:

- Level 1: Professionals scrutinising the list of medications patients are receiving to identify potential problems and anomalies;
- Level 2: Utilising patients full medical notes to review medicines; and
- Level 3: Conducting a full face-to-face clinical review where medicines are evaluated in terms of the condition and the patient’s lifestyle (NPC, 2002).

The National Prescribing Centre recommends that pharmacy services are included when performing medication reviews on patients (ibid)

1.7 Packaging and storage issues

The importance of packaging was first recognised in 1968 by the Royal Pharmaceutical Society of Great Britain Professional Standards Inspectors. They stated that, following the Medicines Act of 1968, a properly dispensed medicine must be appropriately packaged or dispensed by a qualified pharmacist (Williams, 1999). In-possession medication in prisons is routinely supplied in a variety of types of packaging, for example cardboard cartons, plastic bottles and monitored dosage packs (DH, 2003).

Difficulties experienced by patients in remembering to take their medications can be addressed by supplying medication in its original packaging. Manufacturers often supply packs which cover commonly prescribed courses of treatment, for example routine regimens of antibiotics. Therefore blister packs can be specially prepared and supplied to assist patients’ drug regimes (NPC, 2005). Using different containers/packaging to the original can be costly in terms of the time needed to prepare and re-package medicine and can potentially cause problems in identifying the medication, requiring extra care to ensure that all appropriate patient information is provided (DH, 2003). Using medication in the original packaging also has the advantage of meeting both the information requirements and labelling criteria required under medicines legislation. Therefore, the Department of Health recommends that medicines should generally be provided in the original patient
packs sent from the supplier. Monitored dosage systems are suggested for use on an individual needs-led basis (ibid). Furthermore, according to guidelines set by the National Prescribing Centre, medication should be dispensed in a clearly labelled container detailing the name of the medication; date dispensed; address where dispensed; quantity; dosage instructions; strength; date of issue; person to who supplied; and any cautionary warnings (NPC, 2005).

Safe and appropriate storage is also a vital consideration when implementing in-possession medication as medicines not stored securely can potentially pose risk to others. Various approaches to this issue have been taken; within hospitals and care homes medications are routinely kept in lockable cupboards. However, options for the safe storage of medication within prisons may be more problematic. Patients in single cells can ensure their door is locked when they are not there; however those in shared cells may have the risk of their medication being readily accessible to another prisoner (Pike, 2005). There are establishments that have already provided lockable cupboards within shared cells, although the use of an additional locked storage place in the cell may impact upon the time taken by wing staff to conduct cell searches (ibid). Specific consideration is required for medication which needs to be stored under particular conditions, for example items requiring refrigeration.

1.8 Evidence of in-possession medication in practice

A case study documented in A Pharmacy Service for Prisoners gave details of three establishments (one category B/C, one category C and one dispersal prison) which provided nearly all medication on an in-possession basis. None of the establishments demonstrated a higher level of harm connected with medicine use compared to prisons with more limited or no in-possession medication. It was also noted that, as a consequence of the accompanying streamlined administrative processes around medication, healthcare provision developed positively in other areas such as healthcare staff being able to utilise the full range of their skills and expertise and improved operation and staffing of clinics (DH, 2003).

In contrast, problems encountered by prison pharmacy services and patients were documented in a case study detailing a patient suffering from diabetes when medication was not supplied IP. Issues highlighted centred on the ordering of medication which was noted to be sporadic. Continuous escorting of the patient to receive insulin injections was required and problems fitting this in around other duties performed by both healthcare and discipline staff were also outlined (DH, 2003). In contrast, the patient’s treatment following the introduction of an in-possession medication policy was also detailed. Following appropriate assessment, the patient was allowed to self-administer medication, using injecting equipment stored in cell. Other advantages to the patient included the successful operation of a repeat prescribing system similar to that conducted within GP surgeries and attendance at a chronic disease management clinic where their treatment was reviewed jointly by medical and pharmacy staff. Furthermore, with medication supplied directly to the patient, pharmacy staff had an opportunity to provide additional professional advice. Discipline staff resources could also be more usefully redeployed due to the reduction in escorts required (DH, 2003).
1.9 The next step

A major challenge within prisons is that of altering negative perceptions regarding in-possession medication and altering a generally risk averse culture to one that is risk aware and capable of pro-active risk management. This is vital in building prison/health partnerships with the goal of promoting individual responsibility (Bradley, 2007). By harnessing a multi-disciplinary approach regarding in-possession medication policies, effective medicines management systems can be usefully employed. It is vital that this is communicated to, and embraced by, all prison staff, not just healthcare staff, thus achieving a balance of security, safety, economic and health related factors (ibid).

1.10 Research aims

The study was commissioned by the department of Offender Health at the Department of Health (DH) to examine current practices around in-possession medication in prison settings in England and Wales.

The study had three aims:

- To determine current policies and practices in relation to in-possession medication across the prison estate in England and Wales;
- To explore the views of key stakeholders, including prisoners and staff, regarding the perceived barriers and benefits of in-possession medication, and suggestions for improving practice; and
- To identify good practice and make recommendations on how in-possession medication policies and practices might best be taken forward across the prison estate.
2. Method

The study adopted a mixed-methods approach incorporating both qualitative and quantitative data. Data collection was divided into two distinct phases:

**Phase 1** - A national survey of all prison establishments in England and Wales to establish current practices in relation to in-possession medication procedures.

**Phase 2** - Semi-structured interviews in 12 prisons to elicit professional and service user perspectives on in-possession medication.

### 2.1 Phase 1: National survey

A national survey of prisons in England and Wales was undertaken in order to establish current practices regarding in-possession medication across the prison estate and between different categories of prison establishment.

**Survey design**

A 24-item survey was developed specifically for the study (see Appendix 1) comprising questions in the following areas:

**Establishment information** - Prison name; job title of staff member completing the survey.

**Verification of medication** - Policies for verifying medication upon a person’s reception into custody and first night/early custody prescribing protocols.

**Medication in-possession** - Use and limits of in-possession medication; policy development; risk assessment; development of establishment formularies; prescribing; medication storage facilities; provision of pharmacy services; and barriers to implementing in-possession medication.

In addition to closed and Likert-scale questions, a number of free text boxes were included for respondents to provide further details of current challenges associated with in-possession medication and/or examples of good practice.
Sample

From HM Prison Service and NHS information sources, 141\(^1\) prisons in England and Wales were identified as eligible to participate in the survey. Of these, 127 establishments returned completed questionnaires. The prisons recruited included all types of prison establishment, including adult male local establishments, prisons holding adult male sentenced prisoners, adult male open establishments, male young offender institutions and female prisons.

Procedure

NHS Research Ethics Committee (REC) approval and HM Prison Service approval under the terms of Prison Service Order 7035 were granted prior to any contact being made with individual prisons.

Invitations to participate and questionnaires were sent by post to all healthcare managers during April 2008. Instructions on how to complete and return the questionnaire were provided along with a Freepost envelope. Respondents were also given the option of completing the survey over the telephone with a researcher, through email or online via a secure survey website. A deadline for responses was given.

Healthcare managers who did not reply within seven weeks were sent another copy of the survey and contacted by telephone within one week. Further copies of the survey were sent to non-responders via post and email and follow-up reminder telephone calls were made for the third and final time four weeks later. The final responses were received in June 2008.

Analysis

Responses were inputted into an SPSS database (SPSS Inc., 2005). Closed questions were analysed using simple descriptive statistics including frequencies and percentages. Written qualitative responses were analysed separately alongside data from individual interviews.

Responses were analysed across the whole sample and by prison type using the following categories: adult local male prisons; adult male sentenced prisons; adult male open prisons; young offender institutions (male) and female establishments (includes both YOI and adult establishments).

2.2 Phase 2: Qualitative interviews

In order to elicit views regarding existing in-possession medication procedures, semi-structured interviews were conducted with a sample of prison staff and

\(^1\) One establishment housed both men and women and returned separate questionnaires for each population. Therefore, for the purposes of this survey this establishment has been counted twice throughout section throughout the results section – once as a female establishment and once as a male local establishment (hence the total of 141 prisons, in England and Wales).
prisoners. The main aim of this part of the study was to identify areas of good practice and suggestions for improvement generated through practice development.

**Interview schedule design**

Separate interview schedules were designed for staff and for prisoners (Appendix 2). Interview schedules comprised a series of open-ended questions and follow-up prompts for clarification. The interview schedules provided structure for the interview whilst allowing the emergence of interviewee-directed topics and themes that had not been identified *a priori*.

Schedules for staff sought to elicit views on how establishments were making in-possession medication work, associated risk assessment and review processes and an overall understanding of both positive and negative aspects of in-possession medication. Prisoner interviews concentrated on individual experiences of the in-possession process and effects, views on storage facilities, the provision of information on medications and any problems experienced with in-possession medication. Interviewees were also given the opportunity to make suggestions for further improvements to in-possession medication procedures.

**Sample**

Twelve prisons were selected to augment the findings of the questionnaire returns; six adult male local prisons (one of which housed both adult and young men); three female prisons; one adult male sentenced establishment; and two male young offender institutions. Establishments were geographically spread across the prison estate.

At each participating establishment efforts were made to interview, as a minimum,  
- The prison governor/deputy governor;  
- The healthcare manager and/or primary care manager;  
- A member of healthcare staff;  
- A member of the pharmacy team; and  
- A member of discipline staff

In addition, other specialist staff involved in prescribing, dispensing, administering or monitoring medication were also recruited where possible, including GPs, psychiatrists, mental health team members and those working in substance misuse services.

Interviews were conducted either on a face-to-face basis, or by telephone, allowing respondents to choose the most time-effective way of contributing. Where researchers were able to visit to perform face-to-face interviews, healthcare staff were also asked to identify a sample of up to four prisoners, received into custody within the previous month and in receipt of prescribed medication whilst in custody. This included both prisoners who were receiving in-possession medication and those that were not.
**Procedure**

NHS research ethics and governance approval and HM Prison Service approval under Prison Service Order 7035 were obtained prior to data collection.

Healthcare managers and Governors at the 12 selected establishments all accepted our invitation to take part in phase 2 of the study. Each participating establishment was asked to identify individuals willing to be interviewed, based on the above list of professional roles. All staff and prisoner participants were provided with suitably written information sheets to allow them to make an informed choice as to whether they wanted to take part in the study. It was made clear that participation was on a purely voluntary basis and that all data would be reported in a way so as to prevent the identification of specific individuals.

Face-to-face interviews were arranged and conducted at six prison sites over the period June to November 2008, comprising of four adult local male prisons, (one of which housed both adult and young male offenders), one female establishment and one prison for sentenced adult males. Telephone interviews were conducted (with staff only) at the remaining six prison sites.

Healthcare managers at the prisons where face-to-face interviews were held identified a number of prisoners to be approached for interview comprising individuals both receiving in-possession medication and others not permitted in-possession. Prisoners were approached to take part by a member of healthcare staff at least three days prior to the interview. On the day of the interview, all participants were given a second opportunity to read through information sheets (see Appendix 3), or they were read aloud, if needed. Participants were given the opportunity to ask questions before informed consent was requested. Participants were reminded of their rights to refuse to answer any or all questions or to withdraw from the interview and/or the study at any time. Where permitted, interviews were audio-recorded. Otherwise, notes were taken by a second researcher acting as scribe. Finally, participants were debriefed and thanked. Following interview, notes were completed or recordings were transcribed.

**Analysis**

Where audio-recordings were available, interviews were transcribed and subjected to thematic analysis. The framework developed by Miles and Huberman (1994) involving a three-stage process of data reduction, data display and conclusion drawing and verification was followed.

A constant comparative method was used to selectively reduce the data (Glaser & Strauss, 1967). This involves generating themes through comparing and contrasting responses in an iterative process. Initially, a detailed micro-analysis of interviewee transcripts and field notes is undertaken, followed by a macro-level analysis concentrating on developing and refining thematic categories.

Following this process, themes were presented visually as a thematic network in order to illustrate more clearly the emerging patterns and inter-relationships between thematic categories and to facilitate conclusion drawing (Attride-Sterling, 2001). Finally, in order to guarantee the ‘confirmability’ and validity of findings, transcripts were revisited during the final stages to verify emerging conclusions.
and ensure that categories were accurately reflective of the data. Several individuals were involved in the analytic process in order to confirm findings, generate new insights and to ensure the conclusions drawn were credible and defensible.
3. Results

3.1 Phase 1: Questionnaire survey

Sample

Overall a 90% response rate was achieved, with 127 establishments participating from a possible 141. All female and YOI male establishments completed and returned the surveys, together with the majority of adult male local, sentenced and open prisons. All analyses henceforth are out of a maximum sample of 127, unless otherwise specified.

Table 1. Questionnaire response rate by prison type

<table>
<thead>
<tr>
<th>Prison type</th>
<th>No. of prisons in England &amp; Wales</th>
<th>No. prisons recruited to study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>100% (46)</td>
<td>87% (40)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>100% (14)</td>
<td>86% (12)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>100% (53)</td>
<td>89% (47)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (14)</td>
<td>100% (14)</td>
</tr>
<tr>
<td>Female</td>
<td>100% (14)</td>
<td>100% (14)</td>
</tr>
<tr>
<td>All</td>
<td>100% (141(^2))</td>
<td>90% (127)</td>
</tr>
</tbody>
</table>

In common with the prison estate in England and Wales, the sample consisted mainly of establishments for adult men, including those for sentenced prisoners (37%), local establishments serving both convicted and unconvicted men (32%) and open prisons (9%). The remainder of the sample consisted of male young offender institutions (11%) and female prisons (11%; Figure 1).

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\(^2\) One establishment housed both men and women and returned separate questionnaires for each population. Therefore, for the purposes of this survey this establishment has been counted twice throughout the results section - once as a female establishment and once as a male local establishment (hence the total of 141 prisons, in England and Wales).
Verification of medication

For this section, we report only the responses of prisons who receive people directly from court. Of the 141 prisons in the overall sample, 45% (n=64) were identified as receiving people directly from court as either convicted or unconvicted prisoners. Eighty nine percent (n=57) of those prisons returned a response to the survey and were asked about procedures relating to the verification and continued prescription of pre-custody medication. Just under half of the sample (42%) reported having a written policy for this process (Table 2).

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes (n)</th>
<th>No (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>45% (18)</td>
<td>40% (16)</td>
</tr>
<tr>
<td>YOI male</td>
<td>29% (2)</td>
<td>57% (4)</td>
</tr>
<tr>
<td>Female</td>
<td>38% (3)</td>
<td>50% (4)</td>
</tr>
<tr>
<td>All</td>
<td>42% (23)</td>
<td>44% (24)</td>
</tr>
</tbody>
</table>

Table 2. Question: For newly received prisoners who report that they are currently in receipt of prescribed medication, is there a written policy regarding the verification and continued prescription of medication?

Survey respondents were asked whether a set time period for making initial contact with outside services had been defined in order to verify a new prisoner’s prescription. The majority of prisons (67%) reported that initial contact with external services was required within one working day of reception (Table 3). The four percent of establishments that selected ‘other’ indicated that time limits varied according to the particular medication concerned.
Table 3.  Question: When prisoners report at reception that they are currently prescribed medication, within what time period does your establishment require that initial contact is made with outside services (e.g. GPs) to verify that information?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Within 1 working day of reception</th>
<th>Within 3 working days of reception</th>
<th>Within 1 week of reception</th>
<th>No defined time period</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>73% (29)</td>
<td>8% (3)</td>
<td>3% (1)</td>
<td>5% (13)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>71% (5)</td>
<td>14% (1)</td>
<td>0% (0)</td>
<td>14% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Female</td>
<td>38% (3)</td>
<td>25% (2)</td>
<td>0% (0)</td>
<td>25% (2)</td>
<td>13% (1)</td>
</tr>
<tr>
<td>All</td>
<td>67% (37)</td>
<td>11% (6)</td>
<td>2% (1)</td>
<td>15% (8)</td>
<td>4% (2)</td>
</tr>
</tbody>
</table>

The majority of establishments (76%), as well as verifying actual prescriptions with external services, reported that they undertook a formal medication review in custody in order to assess the appropriateness of continuing medication prescribed in the community (Table 4). Female establishments were the least likely to automatically perform such reviews; the majority of such establishments (63%) reported that reviews were only conducted if there was a clinical need to do so.

Table 4.  Question: For prisoners in receipt of prescribed medication immediately prior to custody, in which cases are their medications reviewed once in custody?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>In all cases</th>
<th>Verification with outside services not possible</th>
<th>Clinical need to review meds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>80% (32)</td>
<td>3% (1)</td>
<td>18% (7)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (7)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Female</td>
<td>38% (3)</td>
<td>0% (0)</td>
<td>63% (5)</td>
</tr>
<tr>
<td>All</td>
<td>76% (42)</td>
<td>2% (1)</td>
<td>22% (12)</td>
</tr>
</tbody>
</table>
In-possession medication

All survey respondents (100%) reported that they operated a system of allowing in-possession medication. Respondents were asked to furnish the research team with a copy of their current in-possession medication policy, related risk assessment instruments and any other relevant documents. Forty five establishments\(^3\) (32%) sent in-possession medication policy documents. Using the ‘Medication In-Possession A Guide to Improving Practice in Secure Environments’ as a guideline (NPC, 2005) to identify key areas which should be considered for inclusion in in-possession policies, a list of suitable items was created against which to analyse the content of the received policies.

Table 5. In-possession medication policy content analysis: frequency of occurrence within supplied policy documents

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Statement of aims/purpose</th>
<th>Risk assessment process</th>
<th>Monitoring and/or review</th>
<th>Provision of patient information</th>
<th>Patient consent/contract</th>
<th>Security arrangements</th>
<th>Limited prescribing list</th>
<th>Length of supply</th>
<th>Storage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>100% (18)</td>
<td>78% (14)</td>
<td>78% (14)</td>
<td>72% (13)</td>
<td>83% (15)</td>
<td>22% (4)</td>
<td>78% (14)</td>
<td>61% (11)</td>
<td>17% (3)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>100% (1)</td>
<td>100% (1)</td>
<td>100% (1)</td>
<td>100% (1)</td>
<td>100% (1)</td>
<td>100% (1)</td>
<td>100% (1)</td>
<td>0% (0)</td>
<td></td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>83% (10)</td>
<td>83% (10)</td>
<td>58% (7)</td>
<td>50% (6)</td>
<td>92% (11)</td>
<td>33% (4)</td>
<td>58% (7)</td>
<td>75% (9)</td>
<td>42% (5)</td>
</tr>
<tr>
<td>YOI male</td>
<td>70% (7)</td>
<td>100% (10)</td>
<td>70% (7)</td>
<td>60% (6)</td>
<td>80% (8)</td>
<td>30% (3)</td>
<td>50% (5)</td>
<td>90% (9)</td>
<td>10% (1)</td>
</tr>
<tr>
<td>Female</td>
<td>100% (4)</td>
<td>100% (4)</td>
<td>75% (3)</td>
<td>75% (3)</td>
<td>75% (3)</td>
<td>25% (1)</td>
<td>75% (3)</td>
<td>75% (3)</td>
<td>50% (2)</td>
</tr>
<tr>
<td>All</td>
<td>89% (40)</td>
<td>87% (39)</td>
<td>71% (32)</td>
<td>64% (29)</td>
<td>82% (37)</td>
<td>29% (13)</td>
<td>67% (30)</td>
<td>73% (33)</td>
<td>24% (11)</td>
</tr>
</tbody>
</table>

Table 5 shows that the most common features included in an in-possession medication policy were a statement of purpose/aims (89%), patient consent procedures (82%) and details of risk assessment processes (87%). Less frequently included items were guidance on storage facilities (24%) and security arrangements (29%) surrounding in-possession medication.

Respondents were asked which personnel contributed to the development of the in-possession medication policy within their establishments. Healthcare staff were the leading contributors to such policies with pharmacists (87%), nurses (87%) and doctors (82%) being the most frequently cited contributors (Table 6). Contributions to policy design and development were also made by governors (40%) and security staff (53%), with such staff most frequently being involved in establishments for young men. Twenty eight percent of establishments identified other contributors,

\(^3\) The 45 establishments that returned in-possession medication policies consisted of 18 adult male locals, one adult male open prison, 12 adult male sentenced establishments, 10 male YOIs and four female prisons.
most frequently drug and therapeutic committees (n=6), pharmacy technicians (n=5) and community-based PCT staff (n=3).

Table 6.   Question: Who contributed to the development of the in-possession policy?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Governor</th>
<th>Doctor</th>
<th>Pharmacist</th>
<th>Nurses</th>
<th>Security staff</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>40% (16)</td>
<td>88% (35)</td>
<td>90% (36)</td>
<td>90% (36)</td>
<td>55% (22)</td>
<td>23% (9)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>33% (4)</td>
<td>58% (7)</td>
<td>58% (7)</td>
<td>67% (8)</td>
<td>50% (6)</td>
<td>33% (4)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>38% (18)</td>
<td>81% (38)</td>
<td>92% (43)</td>
<td>89% (42)</td>
<td>53% (25)</td>
<td>34% (16)</td>
</tr>
<tr>
<td>YOI male</td>
<td>57% (8)</td>
<td>100% (14)</td>
<td>100% (14)</td>
<td>93% (13)</td>
<td>64% (9)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>Female</td>
<td>36% (5)</td>
<td>71% (10)</td>
<td>79% (11)</td>
<td>79% (11)</td>
<td>36% (5)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>All</td>
<td>40% (51)</td>
<td>82% (104)</td>
<td>87% (111)</td>
<td>87% (110)</td>
<td>53% (67)</td>
<td>28% (35)</td>
</tr>
</tbody>
</table>

The vast majority of respondents reported that there was a system in place for reporting medication errors/adverse incidents (Table 7).

Table 7.   Question: Do you have a system for reporting medication errors/adverse incidents within your establishment?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>95% (38)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>100% (12)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>96% (45)</td>
<td>2% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (14)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Female</td>
<td>79% (11)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>All</td>
<td>95% (120)</td>
<td>2% (3)</td>
</tr>
</tbody>
</table>
Over 90% of the prisons surveyed reported having some form of structured method for determining a prisoner’s suitability to receive medication in-possession (Table 8). Adult male open prisons less frequently reported having a structured risk assessment process.

Table 8. Question: Do you have a structured method for assessing prisoners’ suitability to receive medication in-possession?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>(40)</td>
<td>(0)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>75%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>(9)</td>
<td>(2)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>94%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>(44)</td>
<td>(3)</td>
</tr>
<tr>
<td>YOI male</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>(12)</td>
<td>(2)</td>
</tr>
<tr>
<td>Female</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>(13)</td>
<td>(1)</td>
</tr>
<tr>
<td>All</td>
<td>93%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>(118)</td>
<td>(8)</td>
</tr>
</tbody>
</table>

Risk assessment tools were requested from all establishments and fifty six (47%) of those establishments\(^4\) that reported having a structured method for assessing suitability to receive medication in-possession sent their assessment tools which were analysed thematically. There was wide variance in the format of assessment tools and the types of factors considered in order to judge patients’ suitability to receive medication in-possession.

Figure 2 shows the breakdown of the format of risk assessment tools received. Almost half of instruments (46%) were classified as assessment forms, largely consisting of a range of closed questions allowing only ‘yes’ or ‘no’ answers. Some also included a number of open questions requiring free text answers. Twenty (36%) tools used a points system to determine risk. Such tools typically consisted of a list of risk factors (related to the patient and/or the medication) which were individually scored and added to yield a total score. This score determined the suitability of the patient for in-possession medication and associated restrictions, for example the length of supply of medication. Least commonly (18%) risk assessment tools were in the form of a flow chart, which prompted systematic consideration of the risk factors identified, but did not require the assessor to record any information or complete a form.

---
\(^4\) The 56 establishments that returned risk assessment tools consisted of 21 adult male locals, three adult male opens, 21 adult male sentenced establishments, eight male YOIs and three female prisons.
The most frequently cited risk assessment factors are detailed in the tables below and have been separated into environmental (Table 9) and patient related risk factors (Table 10). Medication issues will be reported separately in relation to those medicines which are typically allowed/prohibited in-possession and differing risk levels assigned to medications.

Table 9 shows that environmental factors were not commonly considered as part of the risk assessment process, although such issues were commonly referred to in in-possession policies themselves. Cell sharing was considered more frequently in the risk assessment process for YOI males (38%), whereas prison location (which also included segregation and therapeutic communities) was more common in the risk assessment tools of adult male sentenced establishments (19%).

Table 9. Contents of risk assessments: environmental factors

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Prison Location</th>
<th>Safe storage</th>
<th>Cell sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>10% (2)</td>
<td>5% (1)</td>
<td>19% (4)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>19% (4)</td>
<td>10% (2)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>YOI male</td>
<td>13% (1)</td>
<td>13% (1)</td>
<td>38% (3)</td>
</tr>
<tr>
<td>Female</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>33% (1)</td>
</tr>
<tr>
<td>All</td>
<td>13% (7)</td>
<td>7% (4)</td>
<td>14% (8)</td>
</tr>
</tbody>
</table>
Table 10 shows the most frequent patient-related factors considered in the risk assessment tools supplied. Suicide and self-harm factors were considered by the vast majority of risk assessment tools (96%). The risk of suicide and/or self-harm was judged in various ways including consideration of past incidents or attempts (sometimes within specified time frames or situations) and an assessment of current risk (usually identified as whether the person had an open ACCT document). Considerations relating to a person’s current mental state included a number of factors such as being in a confused or disorientated state or diagnosis of mental health problems, including depression. The ability to understand the conditions and/or the directions and labels for taking medication was considered in most risk assessments. Finally, just over half (57%) provided a space for staff to note any additional concerns not already addressed by the tool.

Table 10. Contents of risk assessments: patient factors

<table>
<thead>
<tr>
<th>Prison type</th>
<th>History of compliance</th>
<th>Suicide/ self-harm risk</th>
<th>History of substance misuse</th>
<th>Security breaches</th>
<th>Bullied/bullying</th>
<th>Mental state</th>
<th>Understanding of condition/ instructions</th>
<th>Significant life events</th>
<th>Staff concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>52% (11)</td>
<td>95% (20)</td>
<td>38% (8)</td>
<td>62% (13)</td>
<td>62% (13)</td>
<td>71% (15)</td>
<td>62% (13)</td>
<td>14% (3)</td>
<td>52% (11)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>33% (1)</td>
<td>67% (2)</td>
<td>33% (1)</td>
<td>0% (0)</td>
<td>33% (1)</td>
<td>33% (1)</td>
<td>67% (2)</td>
<td>0% (0)</td>
<td>100% (3)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>57% (12)</td>
<td>100% (21)</td>
<td>57% (12)</td>
<td>67% (14)</td>
<td>86% (18)</td>
<td>43% (9)</td>
<td>67% (14)</td>
<td>38% (8)</td>
<td>57% (12)</td>
</tr>
<tr>
<td>YOI male</td>
<td>50% (4)</td>
<td>100% (8)</td>
<td>13% (1)</td>
<td>75% (6)</td>
<td>75% (6)</td>
<td>88% (7)</td>
<td>38% (3)</td>
<td>63% (5)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>0% (0)</td>
<td>100% (3)</td>
<td>0% (0)</td>
<td>100% (3)</td>
<td>33% (1)</td>
<td>100% (3)</td>
<td>67% (2)</td>
<td>0% (0)</td>
<td>33% (1)</td>
</tr>
<tr>
<td>All</td>
<td>50% (28)</td>
<td>96% (54)</td>
<td>39% (22)</td>
<td>64% (36)</td>
<td>70% (39)</td>
<td>61% (34)</td>
<td>68% (38)</td>
<td>25% (14)</td>
<td>57% (32)</td>
</tr>
</tbody>
</table>

Two thirds of prisons (68%) reported that they made use of limited prescribing lists, or formularies, which identified medications which could never be given in-possession (Table 11). Open prisons were less likely to have limited prescribing lists compared to other prison types.

---

5 ACCT (Assessment, Care in Custody and Teamwork) is a care-planning system to help identify and care for prisoners at risk of suicide or self-harm, which has been in place in the Prison Service since April 2007. ACCT was introduced to replace the old F2052SH system, and facilitates a more multi-disciplinary approach to supporting prisoners at risk of suicide or self-harm.
Prisons that reported having such lists were asked to provide copies. Of the 86 prisons that said they used such lists, 36 establishments (42%) supplied copies. The lists varied in terms of complexity; while some establishments simply produced a standard list of medications that could and could not be given in-possession, other prisons had developed more complex classification systems that categorised medications in terms of levels of risk (typically high, medium or low). Furthermore, some prisons provided lists that were clearly intended for use within the broader context of a detailed risk assessment for in-possession medication, typically taking into account patient related factors (e.g. history of self-harm) as well as medication factors.

The analysis highlighted broad agreement in the types of medications categorised as high (usually not in-possession) or low risk (usually in-possession). Those medications most frequently deemed not suitable for in-possession medication, or classed as high risk, were opiate-based analgesics, benzodiazepines, tricyclic antidepressants and certain antipsychotic medicines. Medications more commonly allowed in-possession, or deemed to be medium to low risk, were antibiotics, inhalers, antihistamines, selective serotonin reuptake inhibitor antidepressants and non-opiate analgesics i.e. paracetamol.

The main methods used to determine suitability for in-possession medication across the sample as a whole are compared in Table 12. Overall, whilst some prisons used either a structured method (22%) or a limited prescribing list (2%), the majority of establishments used both (66%). Notably, six prisons (5%) reported that they used neither of these measures. Of these six, two reported that their structured assessment methods were currently in development and one open prison stated that eligibility for in-possession medication was part of their overall acceptance criteria, thus individual assessment was not required.
Table 12. Methods used to determine suitability for in-possession medication

<table>
<thead>
<tr>
<th></th>
<th>Limited prescribing list</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Structured</strong></td>
<td></td>
</tr>
<tr>
<td>assessment method</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>66%</td>
</tr>
<tr>
<td>No</td>
<td>2%</td>
</tr>
</tbody>
</table>

Establishments were asked about the provision of patient information relating to medication and patient contracts for in-possession medication. The majority of establishments sampled (81%) routinely supplied medication information to patients (Table 13). Adult male local prisons were least likely to supply such information, with 28% reporting that they did not do this routinely.

Table 13. Question: Do you routinely supply medication information to patients within your establishment, e.g. patient information leaflets?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>70% (28)</td>
<td>28% (11)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>92% (11)</td>
<td>8% (1)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>89% (42)</td>
<td>4% (2)</td>
</tr>
<tr>
<td>YOI male</td>
<td>79% (11)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>Female</td>
<td>79% (11)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>All</td>
<td>81% (103)</td>
<td>15% (19)</td>
</tr>
</tbody>
</table>

Ninety percent of prisons surveyed required patients to sign a contract before receiving medication in-possession which explained the rules relating to in-possession medication and the consequences of breaching such conditions (Table 14).
Table 14. Question: Do patients sign a contract before receiving medication in-possession?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>88%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>(35)</td>
<td>(3)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>(10)</td>
<td>(2)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>94%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>(44)</td>
<td>(3)</td>
</tr>
<tr>
<td>YOI male</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>(13)</td>
<td>(1)</td>
</tr>
<tr>
<td>Female</td>
<td>86%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>(12)</td>
<td>(0)</td>
</tr>
<tr>
<td>All</td>
<td>90%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>(114)</td>
<td>(9)</td>
</tr>
</tbody>
</table>

When asked how often in-possession medication practices were reviewed, prisons most frequently responded that the timing of reviews was dependent upon clinical factors (63%) and, additionally, if there were any environmental changes or alterations in the patient’s condition (49%). It is also interesting to note that two adult male open establishments reported that they never reviewed in-possession medication. Thirty two percent of prisons reported reviewing in-possession medication at fixed periods, for example every 28 days, three months or six months.

Table 15. Question: How often is in-possession medication reviewed?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Never</th>
<th>No specific time frame</th>
<th>Depends on clinical factors</th>
<th>Depends on patient/environmental changes</th>
<th>Routinely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>0%</td>
<td>3%</td>
<td>70%</td>
<td>48%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(1)</td>
<td>(28)</td>
<td>(19)</td>
<td>(14)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>17%</td>
<td>17%</td>
<td>33%</td>
<td>33%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>(2)</td>
<td>(4)</td>
<td>(4)</td>
<td>(3)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>0%</td>
<td>19%</td>
<td>57%</td>
<td>44%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(9)</td>
<td>(27)</td>
<td>(21)</td>
<td>(19)</td>
</tr>
<tr>
<td>YOI male</td>
<td>0%</td>
<td>21%</td>
<td>79%</td>
<td>57%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(3)</td>
<td>(11)</td>
<td>(8)</td>
<td>(4)</td>
</tr>
<tr>
<td>Female</td>
<td>0%</td>
<td>21%</td>
<td>71%</td>
<td>71%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>(0)</td>
<td>(3)</td>
<td>(10)</td>
<td>(10)</td>
<td>(1)</td>
</tr>
<tr>
<td>All</td>
<td>2%</td>
<td>14%</td>
<td>63%</td>
<td>49%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>(18)</td>
<td>(80)</td>
<td>(62)</td>
<td>(41)</td>
</tr>
</tbody>
</table>
Forty four percent of prisons reported providing specific storage facilities for patients with in-possession medication (Table 16). There were variations in this across prison types; only 20% of adult male local prisons and 29% of establishments for young adult men provided specific storage facilities. Female establishments (79%) were the most likely to provide specific storage facilities.

Table 16. Question: Do you provide specific storage facilities for patients with in-possession medication within your establishment?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>20%</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>(8)</td>
<td>(31)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>67%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>(8)</td>
<td>(4)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>53%</td>
<td>43%</td>
</tr>
<tr>
<td></td>
<td>(25)</td>
<td>(20)</td>
</tr>
<tr>
<td>YOI male</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td>(4)</td>
<td>(10)</td>
</tr>
<tr>
<td>Female</td>
<td>79%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>(11)</td>
<td>(2)</td>
</tr>
<tr>
<td>All</td>
<td>44%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>(56)</td>
<td>(67)</td>
</tr>
</tbody>
</table>

Lockable cupboards were the most commonly provided storage equipment overall (28%; Table 17). Six establishments also stated that prisoners occupied single cells and had their own keys enabling them to lock their doors, thus negating the need for separate storage facilities for medication. Other responses included storage facilities such as cupboards and boxes which were not lockable.
Table 17. Types of storage provided

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Fridge, lockable</th>
<th>Plastic box, lockable</th>
<th>Cupboard, lockable</th>
<th>Box, lockable</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>10% (4)</td>
<td>8% (3)</td>
<td>5% (2)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>17% (2)</td>
<td>8% (1)</td>
<td>50% (6)</td>
<td>0% (0)</td>
<td>50% (6)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>2% (1)</td>
<td>0% (0)</td>
<td>34% (16)</td>
<td>4% (2)</td>
<td>30% (14)</td>
</tr>
<tr>
<td>YOI male</td>
<td>14% (2)</td>
<td>0% (0)</td>
<td>14% (2)</td>
<td>0% (0)</td>
<td>21% (3)</td>
</tr>
<tr>
<td>Female</td>
<td>7% (1)</td>
<td>0% (0)</td>
<td>57% (8)</td>
<td>14% (2)</td>
<td>29% (4)</td>
</tr>
<tr>
<td>All</td>
<td>5% (6)</td>
<td>1% (1)</td>
<td>28% (36)</td>
<td>6% (7)</td>
<td>23% (29)</td>
</tr>
</tbody>
</table>

Respondents were also asked to comment on what routinely happen to people’s medication when they were away from the prison, for example whilst attending court, or being transferred to another establishment. Overall, forty seven percent of establishments reported allowing prisoners to have medication on their person whilst away from the prison (Table 18). This varied widely across prison types with, perhaps understandably, the highest rate being reported by open prisons (92%) contrasted with only half (50%) of female establishments and just over a third (35%) of adult male local establishments. Twenty five percent of establishments stated that allowing prisoners to have in-possession medication whilst being away from the prison was not a blanket “yes or no” policy, rather it was dependent upon a number of factors, including the type of medication and the condition concerned. For example, such considerations meant that inhalers for asthma were generally allowable IP, whilst injecting equipment for diabetes was not.
Table 18. Question: Are patients normally in receipt of in-possession medications allowed it on their person whilst away from the prison e.g. being transferred to another establishment or to a court appearance?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes (NHS)</th>
<th>Yes (Prison)</th>
<th>Yes (Other)</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>48% (19)</td>
<td>25% (10)</td>
<td>20% (8)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>33% (4)</td>
<td>25% (3)</td>
<td>25% (3)</td>
<td>8% (1)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>62% (29)</td>
<td>9% (4)</td>
<td>23% (11)</td>
<td>2% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>50% (7)</td>
<td>7% (1)</td>
<td>14% (2)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>Female</td>
<td>36% (5)</td>
<td>36% (5)</td>
<td>7% (1)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>All</td>
<td>50% (64)</td>
<td>18% (23)</td>
<td>20% (25)</td>
<td>5% (6)</td>
</tr>
</tbody>
</table>

The majority (88%) of respondents reported that a drug and therapeutic committee monitored prescribing activity at their establishment (Table 19). These were most likely to be based within the NHS (50%) rather than within a prison (18%) or other organisation (20%). However, ‘other’ most commonly referred to joint NHS and prison drug and therapeutic committees. Only six prisons (5%) reported that their prescribing activity remained unmonitored by a drug and therapeutic committee.

Table 19. Question: Does a drug and therapeutic committee monitor prescribing activity in your establishment?
Each establishment provided details of the nature of their pharmaceutical service (Table 20). The single most common type of pharmaceutical provision was from independent providers (36%). Thirty percent of establishments stated that their pharmacy services were provided onsite, and 20% reported that they were delivered by a satellite pharmacy based within another prison.

**Table 20. Question: Who provides the pharmacy and related services to your establishment?**

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Onsite pharmacy</th>
<th>Satellite (another prison)</th>
<th>Independent provider</th>
<th>Local NHS trust</th>
<th>No pharmaceutical input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male local</td>
<td>56% (23)</td>
<td>10% (4)</td>
<td>25% (10)</td>
<td>8% (3)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Adult male open</td>
<td>0% (0)</td>
<td>25% (3)</td>
<td>67% (8)</td>
<td>8% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Adult male sentenced</td>
<td>26% (12)</td>
<td>17% (8)</td>
<td>39% (18)</td>
<td>17% (8)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>YOI male</td>
<td>7% (1)</td>
<td>36% (5)</td>
<td>21% (3)</td>
<td>36% (5)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Female</td>
<td>14% (2)</td>
<td>36% (5)</td>
<td>43% (6)</td>
<td>7% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td>30% (38)</td>
<td>20% (25)</td>
<td>36% (45)</td>
<td>14% (18)</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Prisons were asked when sleeping tablets and night time medication were usually administered to patients. The majority of prisons administered such medication as a single, daily dose between 4pm and 9pm (54%), thus raising questions about the appropriateness of medication times for night sedation. Twenty four percent (n=30) of establishments used the ‘other’ category, 13 of which (9%) reported that such medication was routinely given IP.
Table 21. Question: At what times are sleeping tablets and night time medication administered in your establishment?

<table>
<thead>
<tr>
<th>Prison Type</th>
<th>Before 4pm</th>
<th>Between 4pm and 9pm</th>
<th>After 9pm</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Male Local</td>
<td>5% (2)</td>
<td>58% (23)</td>
<td>15% (6)</td>
<td>20% (8)</td>
</tr>
<tr>
<td>Adult Male Open</td>
<td>17% (2)</td>
<td>25% (3)</td>
<td>8% (1)</td>
<td>25% (3)</td>
</tr>
<tr>
<td>Adult Male Sentenced</td>
<td>9% (4)</td>
<td>45% (21)</td>
<td>13% (6)</td>
<td>28% (13)</td>
</tr>
<tr>
<td>YOI Male</td>
<td>0% (0)</td>
<td>79% (11)</td>
<td>7% (1)</td>
<td>14% (2)</td>
</tr>
<tr>
<td>Female</td>
<td>0% (0)</td>
<td>71% (10)</td>
<td>0% (0)</td>
<td>29% (4)</td>
</tr>
<tr>
<td>All</td>
<td>6% (8)</td>
<td>54% (68)</td>
<td>11% (4)</td>
<td>24% (30)</td>
</tr>
</tbody>
</table>

Then and now: 2003 versus 2008

In 2003, the document *A Pharmacy Service for Prisoners* (DH, 2003) set out a vision for the development of more patient focused, needs based prison pharmacy services. Part of the 2003 document reported findings from a survey of 100 prisons on various aspects of their then current pharmacy arrangements. Several of the questions asked in this report are similar in nature to those included within our own survey, thus providing a basis for comparison in responses over time.

Table 22 identifies four key comparators that were measured both in the 2003 DH survey and the current study. In terms of the proportion of establishments that had an in-possession policy, this increased from 92% to 100% over the intervening five year period. There appears to have been a 22% increase since 2003 in the proportion of establishments using limited prescribing lists (from 46% to 68%) and a 29% increase in the number of prisons with a drug and therapeutic committee (59% to 88%).
Table 22. Key findings: a comparison of selected comparators from the current survey (2008) with those reported by the DH in 2003

<table>
<thead>
<tr>
<th>Comparator</th>
<th>2003(^6)</th>
<th>2008(^7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with an in-possession medication policy</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>% with a limited prescribing list</td>
<td>46%</td>
<td>68%</td>
</tr>
<tr>
<td>% with a drug and therapeutic committee</td>
<td>59%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Figure 3 illustrates a number of changes in terms of the types of pharmacy service providers that prisons use. Over the past five years both the number of prisons with onsite pharmacies and the number that contract services from local NHS trusts have remained broadly similar. However, the use of independent providers has increased from 15% to 36%. Conversely, there has been a 30% decrease in the number of prisons using satellite services provided by other prisons (50% to 20%).

Figure 3. A comparison of prison pharmacy service providers in 2003 and 2008

\(^6\) Response rate 73% (100/137)
\(^7\) Response rate 90% (127/141)
Summary of questionnaire survey findings

The key findings from this section of the results can be summarised as follows.

- A 90% response rate was achieved. Responses were received from all types of prisons and are therefore likely to be representative of the whole estate.
- All respondents reported in-possession medication operating within their establishments in some form.
- Under half of prisons (42%) had a written policy relating to the verification and prescription of medication for newly received prisoners. However, most prisons reported that they did aim to verify prescriptions within three days of reception into custody.
- Healthcare staff were the main contributors to the development of in-possession medication policies. Governors and security staff also contributed to in-possession policies in over half of the prisons surveyed.
- While the majority of in-possession medication policies included sections on risk assessment and monitoring/review (87% and 71% respectively), fewer detailed security arrangements surrounding in-possession medication and storage (29% and 24% respectively).
- Most establishments (93%) used a structured risk assessment method for assessing suitability for in-possession medication. However, these varied in terms of structure and the types of risk factors assessed. The vast majority of these specifically considered risk of suicide/self-harm (96%).
- The main prompts for reviews of in-possession medication were clinical factors (63%) and/or changes to a patient’s condition or their environment (43%). Two establishments (both open prisons) reported that they never reviewed suitability for in-possession medication.
- Approximately half of establishments (44%) reported that they provided specific storage facilities for in-possession medication. Local prisons and young offender institutions were the least likely to provide storage facilities.
- Since 2003, there has been an increase in the number of prisons that report having a drug and therapeutic committee and in the number that use limited prescribing formularies. There have also been changes in the types of pharmacy providers used, with decreased use of satellite prison pharmacies and an increase in the use of independent providers.
### 3.2 Phase 2: Semi-structured interviews

A sub-sample of 12 prisons that responded to the questionnaire survey where selected to augment the findings of the questionnaire returns. Semi-structured interviews were held with a range of key informants in a number of establishments (Table 23). The sample consisted of six adult male local prisons (one which held both adult and young adults), three female prisons, one adult male sentenced establishment and two young offender institutions.

In total, 92 interviews were conducted, 68 with staff and 24 with prisoners across the 12 establishments.

#### Table 23. Number of interviewees recruited by discipline

<table>
<thead>
<tr>
<th>Interviewee Discipline</th>
<th>Number interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governor/director</td>
<td>6</td>
</tr>
<tr>
<td>Healthcare management</td>
<td>14</td>
</tr>
<tr>
<td>Primary care</td>
<td>11</td>
</tr>
<tr>
<td>Reception nursing</td>
<td>9</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>10</td>
</tr>
<tr>
<td>Discipline</td>
<td>7</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>4</td>
</tr>
<tr>
<td>Mental health nursing</td>
<td>7</td>
</tr>
<tr>
<td>Prisoners</td>
<td>24</td>
</tr>
<tr>
<td>Total interviews</td>
<td>92</td>
</tr>
</tbody>
</table>

The semi-structured interview schedule covered a variety of aspects connected to in-possession medication including: how establishments were implementing in-possession medication guidelines and systems; details of risk assessment processes conducted; positive and negative aspects of in-possession medication...
regarding patient benefits and security concerns; and the monitoring of treatment concordance in patients who have medication in-possession.

**Verification of medication**

Overwhelmingly, respondents reported that a prisoner’s reported prescribed medication was verified by contacting the relevant external healthcare provider, whether that is a general practitioner, community mental health team, substance misuse service or the healthcare team at another prison.

“The only thing we can do is contact their GP. If they are not registered with a GP, we contact their next of kin or guardian and if they are under the mental health team...we contact someone from the team.”

Nurse

Interviewees at all prisons reported that verifying medication with external sources was routine, although only some specifically noted that the prisoner’s written consent to release information was sought. Reception nurses at three establishments and a healthcare manager at a fourth suggested that whether medication was externally verified or not could depend on if a prisoner was able to produce medication with his/her name on it. Two respondents, a governor and a pharmacist from different establishments conceded that they were unfamiliar with any procedures concerning ways or verifying medication.

**Actions where immediate verification not possible**

Staff reported having developed strategies to minimise interruptions to treatment when faced with difficulties or delays in being able to contact external agencies in order to verify prescriptions. These included seeking verbal confirmation from the healthcare provider, giving medication in the short term before verification or prescribing to meet apparent immediate need.

“If it’s something urgent, we can phone the GP and get that verified urgently.”

Healthcare manager

“[If] it was clear that they were a diabetic, then we’re not going to wait two days to give them some insulin, there’s a common sense approach.”

Healthcare manager

“It’s up to the prescriber’s discretion...I would say we’ll give you this, but we’ll be checking with your GP. If it came to it that he wasn’t on that, then I could discontinue it.”

Healthcare manager
“Based on examination, [we] sometimes prescribe antihypertensives [or] anti-inflammatory.”

GP

Generally, these ways of working were noted by healthcare managers; however substance misuse workers at two establishments also suggested that this approach could encompass the provision of symptomatic relief for opiate withdrawal.

**Barriers to verification of medication**

It was reported that the process of verifying medication was complicated in a variety of ways. Such complications could be divided broadly into three categories: external factors, factors relating to the prisoner and factors associated with the establishment itself.

*External factors*

New prisoners routinely arrive at the end of courts’ daily sessions, which means they are seen by healthcare staff in reception beyond the hours of availability of many external healthcare services, for example mental health team or substance misuse services. Clinical staff from several establishments commented that this resulted in problems contacting community healthcare providers on the actual day people arrived in prison.

“Getting hold of GPs depends on gatekeepers, (their) reception staff can be helpful but the problem is Friday, Saturday and Sunday and when trying to contact them on Monday, it’s a busy time for GP surgeries.”

Primary care manager

Respondents from several other establishments further reported that information did not necessarily arrive as quickly as would be ideal.

“Can take a number of days to verify; women get distressed in that time at not receiving their medication.”

Discipline officer
Several interviewees suggested that there was a tendency towards suspicion or non-cooperation on the part of proximal healthcare providers

"Surgeries may be reluctant to give out information."
Pharmacist

"Coming from a prison, you’re viewed with suspicion."
Healthcare manager

"GPs don’t realise we are part of the NHS and try to charge [for information]"
Reception nurse

"[We] can get an anti-helpful attitude, even if we state it’s for continuity of care. Some won’t give information over the phone."
Discipline officer

One member of nursing staff complained specifically that courts provided insufficient information.

"For 16 and 17 year olds there should be the ASSET\(^8\) forms and pre-court reports but hard copies of these are not being sent now. They tend to come a little bit later by fax, so those are barriers."
Reception nurse

Another senior nurse reported that other prisons did not consistently send prescription charts with transferred prisoners. One pharmacist interviewed stated that when information was received, it was not always correct.

**Prisoner related factors**

Clinicians from several establishments reported that prisoners themselves could often complicate the process of medication verification. The most frequently cited reason for this was that they were unable to recall relevant details.

"Can be difficult due to the population type, forgetting GP details, under the influence."
Primary care manager

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\(^8\) ASSET is a structured assessment tool used by YOTs in England and Wales on all young offenders that come into contact with the criminal justice system. (Assessment and diagnosis, Structure, standardisation and scoring, Screening and suitability, Evaluation, effectiveness and evidence; and Targeting).
A smaller number of respondents suggested a more deliberate lack of cooperation.

“Occasionally, prisoners can be uncooperative”

Pharmacist

There were a sufficient number of responses to suggest that it was not uncommon for newly received prisoners to have no community healthcare provider.

“Sometimes [surgeries] can’t give us any information because the prisoner has not been registered or has been taken off their books so we may have to chase a couple of avenues to get any information.”

Primary care manager

**Internal factors**

Three respondents (two at the same establishment) expressed a belief that there was a lack of a robust system to verify medication.

“No good system in place, and there needs to be.”

Reception nurse

One of the interviewees expressing this view was a governor. Two respondents made specific comments in relation to the process being hampered by perceived staffing deficits.

“We don’t have a dedicated person to do the follow-up.”

Substance misuse nurse

The issues with verification of medication are evidenced in reports from prisoners in the delay in receiving medication they were prescribed in the community

“Take meds off me, not allowed to bring the one from outside. Took a week... I had to press them for a while.”

Prisoner

**Improvements to verification of medication**

**External factors**

A large proportion of respondents argued in favour of a national/regional database which would allow information on a prisoner’s health and prescribed medication to be accessed directly.
“If prison health records were centralised, this would make it better.”

Primary care manager

“A computerised system would be wonderful”

In-reach team member

This was a view primarily expressed by clinical staff, but one prison officer made a similar recommendation. One interviewee openly expressed the opinion that whilst an IT solution would be helpful, this was an unrealistic aspiration.

“Common database management of it, though that’s pie in the sky.”

Unattributed

Two respondents argued that an extension of GP opening hours would be beneficial to the process, although one felt this unlikely to be achieved. Two respondents, a nurse and a discipline officer, suggested that courts could be more proactive in obtaining information.

Internal factors

Some respondents suggested that staff within the prison should foster stronger links with community healthcare providers or pharmacists. One interviewee suggested that if prisoners were received from a smaller catchment area, this would allow their prison to establish better working relationships with relevant GPs. Two respondents suggested specific amendments to working practices, including the “personal touch” might speed up the process.

“If we can speak to the secretary instead of faxing, because if you get a fax you tend to put it aside whereas if you’re speaking to someone, you can get the information there and then.”

Reception nurse

“The nurses should come to pharmacy in the morning so we can dispense that day. Otherwise we have to wait till the next day.”

Pharmacist

In-possession medication

There was significant variation across the prison estate regarding the proportion of in-possession (IP) medication although few respondents discussed this in detail and none were able to provide accurate statistics with confidence.

“Around 90% are on IP”

Pharmacist
“Very few inmates are on in-possession”
Substance misuse team leader

“It happens, but we don’t have as much as at other prisons.”
Governor

Where respondents made comments based on personal experience of the operation of in-possession medication at their establishment these were generally positive.

“In-possession tablets are not a major concern.”
Governor

“Right balance, very few IP issues.”
Discipline Staff

However, the governor of one prison was especially negative in his general opinion of in-possession policies, perhaps highlighting that notions of equivalence of healthcare provision may have some way to go to be fully accepted.

“I don’t think there are any positives.”
Governor

Overall, interview findings did not suggest significant differences in the opinions of discipline and healthcare staff, although a number of healthcare interviewees reported perceiving opposition from HM Prison Service employees which they felt constrained the in-possession process.

“Security had a knee jerk reaction to in-possession implementation which was negative [but] they are coming around”
Primary care manager

Two healthcare workers interviewed expressed dissatisfaction at a perceived low rate of in-possession prescribing within their establishment.

“The negative is that we can’t give enough IP.”
Clinical Nurse

“[It’s] not working nearly enough, more could be done. More prisoners should have IP, only a small proportion has.”
Pharmacist
Risk Assessment

Generally, the decision to prescribe medication in-possession was based on risk assessments which were frequently, but not invariably, based on structured documents.

“We have a tick box form asking about self-harm, have they seen a doctor, is there any known misuse of medication, are there any mental health issues. These are all yes/no quick fire questions…and you make a risk assessment from that.”

Reception Nurse

“No formal risk assessment, based on person.”

Lead Nurse

Establishments varied according to when people were risk assessed for suitability for in-possession medication, with some conducting the assessment at reception and others waiting until the prisoner had been assessed by a doctor as requiring some type of medication.

“Got IP when got to know you and trusted you”

Prisoner

There was little consistency between establishments regarding which staff were responsible for the risk assessment process; some respondents described it as an example of multidisciplinary team working whereas, at other prisons, the work was undertaken wholly by the doctors and/or nurses. In some cases, discipline staff were involved in the risk assessment process, though this was not necessarily welcomed by the prison staff.

“It’s a medical thing, not for us to get involved with, and should stay a medical thing.”

Discipline officer

A variety of respondents expressed opinions on the risk assessment process, generally those involved in directly delivering clinical care. Strikingly, the majority of pharmacists interviewed had somewhat negative perceptions of current risk assessment processes. Generally, they expressed a view that risk was dynamic and that existing assessment processes did not reflect this.

“In a month’s time, something might have happened. [There’s] an issue of how often to repeat.”

Pharmacist
A number of respondents regarded the assessment forms in current usage as outdated and not necessarily reflective of current prescribing practices.

“The risk assessment document is out of date. More medication should be added.”

Pharmacist

“The risk assessment is historic, at least two years old.”

Pharmacist

Interviewees from other disciplines shared concerns about the robustness of the risk assessment process, commenting that it was insufficiently thorough or unduly influenced by staff opinion.

“Can be subjective, scores vary according to rater and rater’s knowledge of prisoner”

Healthcare manager

One respondent suggested that structured risk assessment was not a substitute for a detailed knowledge of the client base, with objectivity assured by valuing contributions from a number of disciplines involved with the prisoner.

“Any assessment could not improve on incidents, [you’ve] got to know your lads.”

Reception Nurse

In general, nursing and medical staff were slightly more positive about the risk assessment process than pharmacy colleagues. Discipline staff tended not to comment on this area. Certain groups of prisoners were frequently reported as being automatically excluded from in-possession arrangements, for example units where prisoners felt to be at risk of suicide or self-harm lived.

“On the Safer Custody unit, we try not to have IP where possible.”

Discipline Staff

At one establishment, there was a degree of flexibility reported in this arrangement, dependent on the type on medication in question.

“If on ACCT, it dictates [they] can’t have medication in-possession, but there’s some leeway with antibiotics.”

Reception nurse

Some staff described varying the duration/amount length of medication supplied in-possession according to perceived risk, varying between two and twenty eight
days. At some establishments, certain types of medication were not given IP, or only given for a restricted time.

“Certain medications, they cannot have in-possession…it’s just very basic stuff like ibuprofen.”

In-reach team member

“We mainly give medication which cannot be misdirected.”

Substance misuse nurse

Typically, medications not given IP were either those for mental health issues, or those with a perceived increased potential for self-harm.

“No antipsychotic medication is given IP because of the side effects.”

Discipline officer

“Paracetamol is only given for three days because of the risk of overdose.”

Primary care manager

In one case, certain medications were never given in-possession because of the perceived personal and institutional risks of non-concordance.

“We would never give any of our prisoners anything for their TB because we need to ascertain and ensure they have effectively taken the whole course to minimise the risk to themselves and the rest of our population.”

Primary care manager

**Other Security Measures**

In order to reduce the potential for abuse, it was reported as common practice that people signed a contract/compact promising not to trade or otherwise misuse their medication before in-possession was sanctioned. Prisoners interviewed who had supplies of medication in-possession were generally able to recall signing such a contract. Typically, medication was given at predetermined intervals in order to minimise risk. These intervals generally appeared to vary according to the type of medication, the nature of the prisoner and also allowed for ongoing review. Different types of packaging, for example weekly blister packs, were used to contribute to helping prisoners take medication as prescribed and to make it easier for staff to monitor concordance. One respondent reported that their establishment was introducing systems specifically to improve prisoners’ understanding of their medication.
Primary care manager

Generally, prisoners interviewed stated that they were satisfied with the amount of information they had received about their medication.

**Monitoring of IP**

A variety of monitoring strategies were reported, often within the same establishment. Monitoring was frequently viewed as a collaborative process, involving security staff and various clinical professions. One non-clinical respondent suggested that no monitoring took place, though two colleagues from the same prison disagreed, one indicating that at least two of the more popular methods were employed. This suggested a degree of uncertainty and a lack of uniformity in monitoring processes, in at least that institution. The variety of responses to this subject did not consistently suggest the presence of structured, proactive monitoring, though the overall impression gained was that some form of monitoring did occur generally.

A number of respondents cited regular reviews of patients’ care and progress as a method to minimise the risks of in-possession medication.

> "It’s about reviewing patients, taking time to speak to them when [they] collect their IP”

In-reach team member

Establishments differed according to whether monitoring was the responsibility of nursing, medical or pharmacy staff. In some establishments, monitoring was undertaken primarily in the context of structured appointments.

> "You can monitor them by making an appointment for them to see the nurse once a week."

Clinical Nurse

Others commented more generally on the need to develop a broader therapeutic alliance with patients.

> “Chatting to them, about knowing and talking to your prisoners.”

Healthcare officer

One respondent suggested that the person’s clinical presentation might be an indication of problems with concordance.
"We would notice lads were not taking them by the way they were acting, for example, their mood if not taking antidepressants.”

Reception nurse

One respondent expressed concerns about the effect on the therapeutic alliance with clinical staff involved in the monitoring of medication concordance and the need to strike the correct balance between being concerned about concordance for clinical, rather than security driven reasons.

"Have to be careful not to get into a punitive role.”

Healthcare manager

Some respondents reported that reviews took place at predetermined frequencies, often when the previous prescription/supply had expired.

A number of respondents commented on cell searches which appeared in some prisons to be undertaken solely by security staff, whereas nursing staff were also involved in other establishments. One respondent expressed ethical concerns about the involvement of clinical staff in this area.

"I don’t think healthcare should be involved in that kind of punitive, cell searching initiatives. I think that’s ethically wrong.”

Healthcare manager

Another commented on possible adverse effects of such practices on the relationship between staff and prisoners.

"Nurses can inspect but this is rare, not easy to do, and might be difficult to interact with patient afterwards.”

GP

A number of respondents reported that evidence of non-concordance or inappropriate taking of medication could be obtained where there was a discrepancy between the duration of the prescription and the date of a requested repeat supply. In one establishment, a plan had been introduced for nursing staff to interview prisoners under such circumstances. Several respondents reported that prisoners were intermittently asked to show their medication containers in order to establish that actual consumption tallied with what would be expected. One respondent described the use of blood testing to monitor concordance at his establishment.
Prisoners themselves remarked that the convenience of having IP medication readily to hand increased the likelihood of them remaining concordant with treatment regimes.

“They come proper early when I’m still asleep...I wouldn’t be bothered. I have gotten into the routine of taking my medication.”

Prisoner

“I wouldn’t take them if I had to queue up for them. I can’t be messing about with all that.”

Prisoner

“Prefer to have on me, to stop missing stuff.”

Prisoner

**Benefits of IP**

Benefits to both institution and individuals were identified. Generally favourable comments were more likely to be made by clinical staff, but discipline officers and governors were also able to identify at least some positive aspects.

**Resources**

Both clinical and prison staff described benefits in terms of reduced staff time needing to be spent on medication rounds.

“There’s less of a burden for healthcare staff and they would have more time for other patients who need daily medication given to them.”

Pharmacist

“Saves us time having to open cells to issue medication.”

Discipline officer

It was suggested this was advantageous to staff and prisoners who did not have in-possession medication, as clinical staff were able to spend more time with them as a consequence. Similarly, a reduction in the size and number of medication rounds was noted as beneficial.

“There are four medication rounds a day and if we had more IP, we could probably reduce that down to two and we could reduce the numbers from ninety to about thirty.”

Healthcare manager

One respondent suggested that, without some IP, the prison regime as a whole would become dysfunctional.

“We would never get the system up and running if we had to (individually) mediate everybody.”
Respondents also suggested security benefits in terms of improving the control and economic efficiency of pharmacy stock, reducing the necessity for patients to congregate and reducing the likelihood of staff being isolated in cells.

"[It] leads to better stock control and audit trail if we have IP, at the moment, it is virtually impossible to know where stock ends up."

Pharmacist

"Non-IP patients come to the hatch all of the time. Not good to have dozens of patients at the hatch."

Pharmacist

"[Before we introduced IP] if there was an incident, it was going on until one o’clock in the morning...Plus you’re opening cell doors with two prisoners in with minimal staff so this was a big security implication"

Discipline officer

A majority of respondents expressed the view that in-possession was beneficial to prisoners through its encouragement of taking responsibility and an active role in their own healthcare.

"Patients take ownership of their own health. Knowledge of their own well being."

Pharmacist

"It’s good in a sense that I can control it, I can have responsibility for it rather than have someone dictate it to me."

Prisoner

It was frequently suggested that this could help prisoners maintain management of their health following release and increase their understanding of medication they were taking.

"Allows prisoners to develop a better understanding of the medication they are taking."

Pharmacist
“Getting our lads to manage their medication effectively and safely and manage their own health and also to pre-plan is helping them to prepare when they are released back into the community.”

Primary care manager

Suggestions were also made that prisoners would also benefit from being able to take medication when they needed it without being restricted by the frequency of nurse led drug rounds, thus improving care and satisfaction.

“With people having pain, they are not having pain waiting for us.”

Healthcare manager

“Handy to have it on me for when I need it”

Prisoner

“I have set times I have to take it, so having to go down there isn’t always easy. There’s a long queue.”

Prisoner

Another prisoner-respondent noted that in-possession improved their ability to take medication at appropriate times, for example not having to take night sedation too early in the evening.

Some interviewees commented that in-possession procedures were helpful in reducing the stigmatisation of prisoners with health problems.

“They don’t like people seeing that they’re on medication, if they have mental health problems, they don’t want to be in a holding cell while getting medicated.”

Reception Nurse

“(having medication IP) makes you feel normal. I’m not a monster, so I should be given my inhaler.”

Prisoner

Many respondents commented that in-possession arrangements were more reflective of the situation in the community and thus in line with the overall concept of equivalence between prison and community in terms of the availability and quality of healthcare provision.

“If they were in the community, they would have a cupboard full of tablets anyway. If we take every responsibility away from them, it’s not giving them any autonomy.”

Healthcare manager

“You’re in control, like in civilian life”

Prisoner
“It’s embarrassing taking supervised drugs.”

Prisoner

Disadvantages of IP

Concerns were raised by both clinical and non-clinical staff over the potential risks of IP. As noted above, a strong condemnation of the policy was expressed by a governor

“I don’t think there are any positives.“

Governor

In terms of security, several respondents commented on the risks of theft of medication and of bullying and violence.

“Putting more medication into cells leads to bullying, particularly in shared cells. [There are] levels of violence because people buy and sell medication.”

Governor

There were also concerns expressed regarding the trafficking or misuse of prescribed medication.

“They do silly things with it, if they can sniff it, swallow it, they’ll do whatever. It’s open to abuse.”

Substance misuse nurse

Some respondents suggested that patients may be less likely to comply with a medication regime without the structure of single dose administration, possibly due to a lack of understanding of the prescribed regime.

“One or two of them have said they’d rather not have it in-possession because they might forget to take it.”

Reception nurse

“A fifteen year old won’t have a clue about how many tablets they have been taking.”

Governor
Others suggested that there was a risk that people would deliberately omit medication in order to cause their health to deteriorate.

"The population can be quite manipulative with the healthcare staff."

Primary care manager

Concerns around the risk of self-harm were the most frequently cited potential problem, with some respondents discussing this in the context of their opinions on the risk assessment process. However, one respondent noted that such risks may be perceived rather than actual.

"[There have been] numerous [reported] suicide attempts with taking tablets, not always true"

Discipline officer

Two of the prisoners interviewed appeared to endorse the comments about risk by suggesting they believed their risk of self-harm was lessened by virtue of their medication being administered under supervision.

"I think it’s [supervised administration] alright, better for me like ‘cos I’d end up keeping it all ‘til I had 200 like and killing myself."

Prisoner

"I’m on an ACCT...no problems taking them in front of other people. They think I am high risk. [I] don’t feel I should have in-possession."

Prisoner

Several other respondents made more general comments about the increased likelihood of deliberate self-harm within the prison population where in-possession was available, where the medication could be used feloniously by someone other than the individual it was prescribed for. The only other disadvantages to in-possession raised by prisoners were in relation to the risk of misuse or theft of medication.

"Gabapentin can be abused, used as currency."

Prisoner

"[Tablets] would either be taken from them by other prisoners, or they would misuse them in my opinion."

Prisoner

**Barriers to IP**

The proportion of medication given IP and perceptions of the overall success of in-possession procedures appeared to vary between institutions. A number of possible
explanations were cited which can broadly be categorised as staff attitudes, prisoner related variables and systems within the prison itself.

Staff attitudes

A number of responses suggested that in-possession policies could face resistance, either from prison or clinical staff.

“HMP [staff] were very frightened, they thought everyone would take all their pills.”

Primary care manager

“Most doctors are apprehensive of our client group.”

Substance misuse team leader

Some comments made suggested these attitudes might have an adverse impact on the roll out and success of in-possession practices. One member of nursing staff suggested that anxiety on the part of doctors reduced their willingness to prescribe medication for in-possession supply. It is perhaps also relevant that a governor who was particularly forthright in his opposition to in-possession reported a lower than average use of this policy at his establishment, thus illustrating the strong influence of key individuals. One respondent suggested that increased understanding in prison staff could usefully change attitudes, echoing the earlier comment from a respondent who noted that views of associated risks were not always proportional.

“There needs to be more understanding within the prison regime. [There is a] perception of how in-possession is a risk...Education needs to take place with regards to in-possession attitudes”

Pharmacist

Prisoners

Other interviewees suggested that in-possession usage was restricted because of the particular profile of the prisoners detained at their particular establishment, either because of the age of prisoners, or the transient nature of the population.

“We don’t allow 15 year olds in-possession as they are still minors.”

Healthcare assistant

“We don’t give out a lot of IP medication because we are a remand prison and we don’t get to know the prisoners before they move on, [we] don’t know how high risk they are.”

Primary care manager
At a number of prisons staff reported that they did not currently offer lockable storage facilities at their establishments. This is of concern in view of the number of respondents who stressed the potential risk of theft or misdirection as a potential disadvantage of IP. In prisoner interviews, there was a striking discrepancy in the perceived security of in-possession medication in cells at establishments with and without lockable storage facilities.

“I don’t think there is any benefit of anyone having their own medication...unless there was a safe place to keep them in your pad.”

Prisoner

Several interviewees, comprising both discipline and clinical staff commented adversely on communication between professionals within the prison. This again adds weight to the argument for a need for increased attention to education about risk for all staff so as to reduce people’s anxieties around in-possession medication.

“Communication between health and security could be better, the relationship is too loose.”

Governor

“There’s no communication between healthcare and security in issues in a prisoner’s life.”

Governor

A lack of communication between staff groups and differential understandings of actual vs. perceived risks were noted as problematic in a number of ways, for example discipline staff finding a prisoner’s in-possession medication in his cell and assuming it to be contraband or, alternatively, failing to recognise when medication is being illicitly traded because they are unaware who should or should not have supplies of medication.

“Sometimes [security staff] will find tablets in a cell and rush them away, even though we have sent an IP notification.”

Primary care manager

“Prison staff do not know what IP is being prescribed so using it as a currency can occur here.”

Governor

One pharmacist complained specifically of inconsistency in ensuring the pharmacy department was advised of changes in a prisoner’s in-possession status in spite of the presence of a computerised clinical information system.
“Pharmacy not informed that [a person has been changed to] no IP, it’s happened, should be done on EMIS [electronic records system] and pharmacy should be informed verbally.”

Pharmacist

Several interviewees suggested that the prison environment was not necessarily conducive to the successful operation of in-possession policies.

“Staff work under extreme conditions, verbal abuse, the environment we work in is not conducive to good care.”

Primary care manager

Prisoners also reported that communication between themselves and staff regarding their medication was sometimes unsatisfactory, with prisoners reporting that they did not know how to order, collect or take medication, or know the conditions of their in-possession medication contracts.

“Did not know had to go to hatch to collect my medication, someone else told me, was not explained to me, staff did not tell me about medication till second screen.”

Prisoner

Whilst acknowledging the negative effect of inconsistencies within individual establishments, the issue is of course further compounded when prisoners are transferred to other establishments where IP policies and practices may be, at best, similar and, more challengingly, wholly different, especially in terms of which medications are allowed IP, how risk is assessed and the measurement of concordance to treatment. If these things vary greatly across prisons, it makes it difficult for prisoners to always be aware of what is expected of them in the IP process.
Summary of interview findings

The key findings from the interviews can be summarised as follows:

- The process of verifying medication was seen to be complicated by several factors including; external factors (late arrival of prisoners after court; information being delayed; and suspicion or non-cooperation on the part of proximal healthcare providers); prisoner (unable to recall relevant details; deliberate lack of cooperation; and newly received prisoners not all having a community healthcare provider); and establishment factors (lack of a robust system to verify medication and lack of dedicated staff).

- Respondents argued in favour of a national/regional database which would allow information on a prisoner’s health and prescribed medication to be accessed directly.

- Respondents stated that prison staff should foster stronger links with proximal community healthcare providers or pharmacists.

- Respondents stated that prisoners should be received from a smaller catchment area.

- Respondents’ personal experiences of the operation of in-possession medication at their establishment were generally positive.

- Interview findings did not suggest significant differences in the opinions of discipline and healthcare staff.

- Establishments varied according to when people were risk assessed, some conducting the assessment at reception and others waiting until the prisoner had been assessed by a doctor.

- Little consistency was noted between establishments regarding which staff were responsible for the risk assessment process.

- The majority of pharmacists interviewed had somewhat negative perceptions of current risk assessment processes. Generally, they expressed a view that risk was dynamic and that existing assessment processes did not adequately reflect this.

- Respondents stated that the assessment forms in current usage were outdated and not reflective of current prescribing practices.

- There were concerns about the robustness of the risk assessment process; respondents commented that it was insufficiently thorough or unduly influenced by subjective staff opinion.

- Respondents stated that it was common practice for prisoners to sign a contract/compact promising not to trade or otherwise misuse their medication before in-possession was sanctioned.

- Monitoring of in-possession medication was frequently viewed as a collaborative process, involving security staff and the various clinical professions.
• Prisoners stated that the convenience of having in-possession medication increased the likelihood of them remaining concordant with treatment regimes.

• Benefits of in-possession medication included; increased resources (reduction in staff time on medication rounds); improved security (the control and economic efficiency of pharmacy stock, reducing the necessity for patients to congregate and reducing the likelihood of staff being isolated in cells); and prisoner autonomy (more responsibility, has an active role in their own healthcare, and increased understanding of medication).

• Disadvantages of in-possession medication were mainly around security issues (bullying, violence, drug trafficking, drug misuse and self-harm).

• Barriers to in-possession policies included; staff attitudes (in-possession policies could face resistance); prisoner factors (due to certain prison populations i.e. age of prisoners, or the transient nature of the population); systems (lack of lockable storage facilities; lack of communication between professionals within the prison; and prison environment was not necessarily conducive to the successful operation of in-possession policies).

The key themes and sub-themes identified within this section have been summarised as a thematic network (Attride-Stirling, 2001) in Appendix 4.
4. Discussion

The NHS and HM Prison Service have, for around ten years, been engaged in a clinical improvement partnership based on the broad principle that prisoners should have access to healthcare services of equivalent scope and quality as are available to the wider population. With regards to medication this means that, when safe and appropriate, prisoner-patients should be given autonomy and responsibility for the storage and administration of their own medication.

In 2003, A Pharmacy Service for Prisoners (DH, 2003) made numerous recommendations with regards to pharmacy services and in-possession medication for prisoners. The current report aimed to evaluate current practices around the operation of in-possession medication policies within prisons in England and Wales; to compare the results to that of A Pharmacy Service for Prisoners, examining whether recommendations had been implemented; and to examine potential ways of ensuring the widest acceptability, safety and efficacy of in-possession medication practices through the adoption of proven community-based strategies, adapted to take into account the discrete security and institutional influences operational within prisons.

Verification of medication

Respondents consistently expressed dissatisfaction with arrangements for verifying prisoners’ prescribed medication upon reception into custody. The overwhelming majority of establishments were described as relying on written and/or verbal confirmation of medication from community healthcare providers, commonly general practitioners or substance misuse treatment services.

Essentially, the pattern described was one of large numbers of prisoners arriving in the late afternoon or early evening, outside the standard operating hours of most community healthcare providers. Consequently, it is often not possible for healthcare staff to determine a prisoner’s prescribed medication until the following working day at the earliest. A possible solution would be for proximal healthcare providers to remain open for longer into the evenings in order to respond to such requests for information. It is unlikely that such a change in working practices in primary care, community mental health teams and substance misuse services could be introduced without resistance, nor indeed be considered a cost-effective use of staff time, given the likely small numbers of patients this would involve for each individual practice. There would be scope for healthcare teams within prisons to ensure they exploit fully those providers which do remain open during the evening on weekdays. Improved access to such information could be a, possible unanticipated, benefit of recent proposals to extend GP opening hours.
An alternative approach would be to take measures to ensure prisoners are received into custody at a time when healthcare staff are able to contact community providers. Courts could be encouraged to commence proceedings earlier in the day, and prisoners be conveyed to prisons at more frequent intervals throughout the day rather than in one movement after courts have closed. Reductions in the catchment areas of individual prisons would reduce the travelling time of secure escort vehicles, both by ensuring vehicles are not required to travel to multiple prisons and by limiting the distance travelled between court and prison on any one journey. Whilst this might result in prisoners being seen by reception staff earlier in the day, changes within the criminal justice rather than in the healthcare system would be necessitated and, given that such proposals have both operational and cost implications, they are likely to be met with resistance.

Where it is possible to contact healthcare providers, their cooperation is not guaranteed and relevant information can take several days to become available. Whilst most prisons have developed contingency plans where such information is not immediately forthcoming to ensure prisoners’ health is not immediately endangered, the situation is still of concern. The frequency with which prison-based respondents complained of such difficulties indicates the importance in determining solutions before adverse events occur. Only a small proportion of the establishments sampled specifically detailed staff time to obtain information from community providers meaning that this task frequently became an additional duty for members of staff already busy conducting vital health screens on newly received prisoners, or conducting busy morning surgeries. Some respondents supported the idea of identifying dedicated staff to verify prescribed medication. Depending on the timing of the prisoners’ arrival into custody, this role could be given to either pharmacy or nursing staff. Such a strategy would ensure this important aspect of the reception process is not marginalised as a result of the need to complete other parts of the screening.

Perceived lack of cooperation from external healthcare providers appears to continue to be a significant obstacle. One respondent suggested that reducing the catchment area served by individual prisons would be helpful in encouraging the development of effective working relationships between community and prison based healthcare teams. Such a proposal could present practical difficulties, however. An alternative approach might be through targeted communication strategies. There may be benefits to the circulation of information leaflets to GP practices and other community healthcare providers, explaining the role of prison healthcare teams and their status within the NHS. This strategy could be complemented by encouraging prison healthcare staff to conduct training sessions for community based colleagues. These could, perhaps, link in with primary care or community health educational meetings where these take place. An additional benefit to such an approach may be to eradicate requests from GPs for payment for providing healthcare information, an issue still reportedly encountered by a minority of prisons.

A number of respondents suggested that prisoners themselves are often uncooperative or unable to provide accurate information. There is no
immediately obvious solution to non-cooperation from prisoners. Where this is a result of limited understanding of prescribed medication on the part of a prisoner, it could be argued that education should be offered by members of the healthcare team, as was available in some of the establishments surveyed. Whilst this would be of limited benefit at reception, it may be helpful if the prisoner is transferred or received into custody on a subsequent occasion. Where prisoners seek to either wilfully deceive staff or chose to behave in a deliberately uncooperative way, there is little that can be done other than ensuring there are other robust mechanisms for determining prescribed medication.

Several respondents suggested prescribing information should be held on a common database which would allow healthcare staff to access written information outside of normal opening hours for community healthcare providers. Assuming such information is secure and up-to-date and that the network is reliable, this would offer a convenient way of ensuring the necessary information is readily accessible however, given the current variable and changeable nature of healthcare information technology systems, such a solution seems some way off.

**In-possession medication**

In 2003, *A Pharmacy Service for Prisoners* (DH, 2003) reported that 92% of prisons had in-possession medication policies. The current study found that this had increased to 100%. Although all prisons allowed in-possession medication, this varied considerably in terms of: the types/form of medications allowed, the duration of supply; and the proportion of people allowed in-possession (up to 100%).

Some respondents were dissatisfied at the level of availability of in-possession medication at their establishment. At a population level, the most significant limiting factor appears to be the attitude of staff. The idea of prisoners having medication in-possession remains somewhat divisive across different groups of staff. Clinical staff are overall more in favour than security staff, but all staff recognised both advantages and disadvantages. Prisoners themselves were similarly divided in their opinions, weighing the advantages of convenience and autonomy against being pressured by other prisoners into giving medication away or acknowledging limits in their understanding of how to manage their own care. Some healthcare professionals remain apprehensive towards in-possession medication in certain populations, notably women prisoners.

Benefits of in-possession medication are noted to include the empowerment of prisoners, reduction of stigmatisation and preparation for discharge from custody in addition to possibly more efficient allocation of staff time. There were also some security advantages in that opportunities for prisoner congregation are reduced as a consequence. The most commonly cited disadvantages were the risks of abuse, non-concordance, theft and bullying.
Only 32% of establishments responded to our request to provide a copy of their in-possession medication policy. Using the *Medication In-Possession A Guide to Improving Practice in Secure Environments* as a guideline (NPC, 2005) to identify key areas which should be considered for inclusion in in-possession policies, analysis of the available policies illustrated an apparently inadequate attention paid to adequate security arrangements or storage facilities, but most did have a statement of purpose, patient consent procedures and details of risk assessment processes.

The current evaluation found that the majority of establishments reported having some form of structured method for determining a prisoner’s suitability to receive medication in-possession. However seven (6%) prisons reported that they used neither a structured method for deciding on in-possession nor a limited prescribing formulary. There was no trend in terms of prison type. In two prisons they stated that such a method was in development, and one Category D prison said that being able to have medication in-possession was part of their acceptance criteria. These establishments may well, therefore, have good multi-disciplinary team procedures regarding in-possession status; however this cannot be clearly inferred in the absence of definitive evidence.

Establishments were asked to provide copies of IP risk assessment tools; just under half of the establishments that reported having a structured method for assessing suitability to receive medication in-possession provided a copy of their instrument. Whilst the risk of adverse events should be reduced by the use of robust risk assessment processes, there appeared to be little consistency between establishments as to how risk assessment was conducted. The format of assessment tools and actual factors considered important for judging a patient’s suitability varied greatly.

Many of the risk assessment tools were form-based, largely consisting of a range of closed questions allowing only ‘yes’ or ‘no’ answers. Some also included a number of open questions requiring free text answers. Some assessment tools used a points system to determine risk. These usually consisted of a list of risk factors which were individually scored and added together to yield a total score. This score determined the suitability of the patient for in-possession medication and associated restrictions, for example the length of supply of medication. A small proportion of risk assessment tools was in the form of a flow chart, which prompted systematic consideration of the risk factors identified, but did not require the assessor to record any information or complete a form.

This evaluation found that there was not an overall, standardised, validated risk assessment tool being used, echoing findings in *Medication In-Possession a Guide to Improving Practice in Secure Environments* (NCP, 2005). The NPC stated that it is unlikely that one will be developed that would meet the needs of all prisons and their differing profiles and populations. The NPC recommended that therefore each establishment should develop its own tool that takes account of local issues, and could be used easily to support the decision-making process. The current situation is therefore one where each prison health care
team or PCT apparently has developed discrete procedures/tools, an apparent replication of effort across the prison estate. Whilst acknowledging the NPC point that prisons vary and that particular problems can be localised, across the prison estate as a whole there is a commonality of issues, especially in prisons with similar functions, for example high secure establishments, local prisons and those holding women or young people. Therefore, there would appear to be an opportunity to collate best practice examples in medication risk assessment across groups of similar prisons to thus develop gold standard risk assessment methods. Such risk assessments would, of course, need to be subjected to rigorous evaluation.

The stage at which risk assessment takes place varied from prison to prison and the personnel involved also differed between establishments. A number of staff expressed dissatisfaction with the risk assessment process at their establishment, suggesting it was either outdated or insufficiently responsive to constantly changing risk dynamics. Some establishments’ risk assessments were carried out on reception; we believe that this is not a good time for such a process to be undertaken, given the likely state of mind of individuals newly received into custody and the already hurried nature of the reception process. Medication In-Possession A Guide to Improving Practice in Secure Environments (NCP, 2005) stated that, amongst the people consulted during the production of the guide, there was much discussion about when the risk assessment of an individual should be undertaken. It was felt that it could possibly be carried out as part of a health care assessment at reception screening in those prisons with a more stable and known population, for examples when people are transferred to training or high secure establishments. For others such as local prisons, where little may be known about new patients, and with huge numbers passing through the reception process in short periods of time, this is likely to be both inappropriate and practically impossible.

Most establishments, when asked how often in-possession medication practices were reviewed, stated that this was dependent upon clinical factors and, additionally, if there were any environmental or social changes in the patient’s condition. It is also interesting to note that two adult male open establishments reported that they never reviewed in-possession medication. Other prisons reported reviewing in-possession medication at fixed periods, for example every 28 days, three months or six months. Medication In-Possession A Guide to Improving Practice in Secure Environments states that risk assessments always needs regular reviewing as risk dynamics can change over time. It is important to note that staff knowledge of individual patients is an important factor in risk assessment, and is an element often hard to capture through the administration of structured risk tools. It is clearly unsatisfactory to rely solely upon individual clinicians’ knowledge of their clients, as it is unsystematic and reliant wholly on individual skills, interest and dedication; however, it is part and parcel of holistic care. Such procedures of course are dependent on staff having intimate knowledge of their clients, something which is likely to be difficult to achieve in busy local prisons with high population turnover.
The majority of prisons surveyed required patients to sign a contract before receiving medication in-possession which explain the rules relating to in-possession medication and the consequences of breaching those rules. Staff, however, need to check if prisoners understand the content and implications of such documents as prisoners often commented that they just signed such contracts, without having full understanding of meaning or implications. Additional consideration of this issue is required where there are issues around levels of literacy which may affect a person’s ability to comprehend information being given to them, or where English is not someone’s first language.

Greater consistency in the risk assessment process is necessary. It would be desirable to implement an agreed, centrally designed, evidence-based structured professional judgement risk assessment policy. This would include procedures to ensure the allocation of responsibility for the risk assessment process to designated individuals and require an initial assessment to take place at a defined point after reception, after which reassessment should occur at a minimum agreed frequency, or in response to particular events, for example a change in legal status or other significant life events. A centrally agreed structured professional judgement risk assessments would ensure that all relevant risk considerations were included for each different type of establishment, provide consistency of approach and smooth transitions between establishments. Should all relevant professionals be suitably convinced medication is only being given after robust risk assessment has taken place, it is possible resistance to in-possession medication may be reduced.

Where in-possession medication is available, there appear to be a number of factors which might increase the risk of adverse events. Several interviewees reported problems in communication between healthcare and security staff and between different healthcare disciplines. Some respondents also discussed the lack of secure storage facilities in cells, a concern given the perceived risk of theft and trading of prescribed medication highlighted by both staff and prisoners themselves.

Assuming the reported advantages of in-possession medication are sufficient to justify the continuation of the practice, it is disappointing that some of the processes necessary to minimise the risk of adverse events are apparently currently applied inconsistently, that communication between staff is variable and that secure storage facilities are not always available, especially in local prisons and young offender institutions. As a matter of urgency, secure, lockable storage facilities should be made available in each cell to reduce the likelihood of medication being stolen.

It is also a cause for concern that the availability of in-possession medication may be being arbitrarily restricted as a result of the subjective opinions of some members of staff or the influence of a small number of senior staff, based on long held beliefs rather than evidence.

There may be advantages to centrally agreeing a policy for the monitoring of in-possession medication in order to ensure problems with non-concordance do not arise. It is also necessary to clarify which areas are the responsibilities of
security staff and which fall under the remit of the relevant healthcare team. In particular, the debate over the active involvement of clinical staff in security-driven cell searches needs to be addressed.

Since non-concordance may result from limited understanding of the reasons why medication is being prescribed, the education of prisoners is likely to be extremely beneficial. The development of pharmacy-led drop-in clinics at some institutions is encouraging, though it may be necessary for teams to be more proactive in their attempts to deliver education to prisoners. This may necessitate involving other staff in either individual or group based education sessions. Prisoners likely to benefit from such input could initially be identified at reception. Medical staff who subsequently prescribe medication could then be encouraged to refer prisoners to the relevant clinician/group, and indeed attend such groups themselves, both to actively contribute and, equally importantly, to learn from their clients.

The establishments were also asked about what routinely happens to people’s medication when they were away from the prison, for example whilst attending court, or being transferred to another establishment. The NCP (2005) recommended that in-possession medication and risk assessments should extend to patients attending court or being transferred and the 2003 DH report recommended sufficient supplies be available while away from the prison. However, less than half of the establishments stated that they allowed prisoners to have medication on their person whilst away from the prison. This issue therefore appears to require a more proactive approach to ensure adequate availability of medication whilst away from prison and warrants further investigation into what the particular barriers are. This would need to be undertaken in conjunction with staff and managers of privately provided escort services, those who staff court cells and police services.

At a number of institutions, certain staff were felt to be cautious or hostile to the concept of in-possession medication. Whilst the above steps, if followed, should make the process significantly safer and transparent, a programme of education for non-clinical staff would be beneficial in challenging obstructive attitudes. In the spirit of improving communication between disciplines, it may be appropriate to conduct risk assessments on a multidisciplinary basis as far as client confidentiality permits.

The majority of establishments reported that a drug and therapeutic committee monitored prescribing activity. Six prisons reported that they did not. Both the NPC (2005) and 2003 DH reports recommended that all prisons, in conjunction with their local PCT, should be covered by a D&TC, or equivalent. These committees draw on specialist expertise and are responsible for the development of medicines and prescribing related policies and procedures. It is the responsibility of this committee to develop risk assessment policies for determining, on an individual basis, when medicines and related devices may not be held in the possession of a prisoner.

Establishments were asked when sleeping tablets and night time medication were administered. The majority said that night sedation was generally
administered as a single dose, between 4pm and 9pm. Therefore this raises question about the appropriateness of medication times for night sedation. In eight establishments, such medication was given before 4pm. This also suggests that medication times and healthcare services are fitting with the prison regime rather than being reflective of best clinical practice.

**Limitations of the study**

There are several limitations to this evaluation that should be noted, with regards to the questionnaire survey, the results are obviously reliant on self-report data and the knowledge of the particular person completing the questionnaire. This can be problematic; for example in one establishment the nurse who completed the questionnaire said that the establishment did not have any medication that was in-possession, however when the healthcare manager was interviewed in the second stage of the study, they confirmed that the establishment did have certain medication available in-possession.
5. Recommendations

1. The default position should be that medicines should be held in the possession of prisoners.

2. Healthcare teams within prisons should ensure that they exploit fully those providers which do remain open after 5pm on weekdays.

3. Local prisons to have as small a catchment area as possible to enhance relationships with proximal healthcare providers.

4. Verification of medication to be tasked to a dedicated member of staff to ensure its completion.

5. Prison healthcare teams should consider producing and circulating information leaflets to GP practices and other community healthcare providers, explaining their role and status within the NHS.

6. Medication education should be offered to prisoners provided by the healthcare team, with specialist input from pharmacy staff.

7. The should be introduced a shared IT system delivering the same level of information and support for the prescribing and supply of medicines that is widely available in the NHS and which allows prisons to access prisoner medical records from other establishments.

8. All prisons should have a locally agreed limited prescribing formulary detailing which medication may/may not be issued in possession.

9. All prisons should be covered by a drug and therapeutics committee or equivalent.

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

11. Consideration should be given to the development of a centrally agreed, evidence-based structured professional judgement risk assessment for in-possesion medication.

12. All cells should have some form of lockable storage.

13. All prisons should have a system of recording adverse events.

14. Sufficient supplies of medicines should be issued to prisoners to cover the whole period they are in court or on transfer using the same IP criteria as are employed within the establishment.
6. References


7. Appendices
Appendix 1: Questionnaire

4. Medication protocols at reception

27. For newly received prisoners who report that they are currently in receipt of prescribed medication, is there a written policy regarding the verification and continued prescription of medication?
   - Yes (Please send a copy of the relevant policy)
   - No

28. Under what circumstances are new prisoners prescribed medication for the following pre-existing health problems on their first night in custody?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Not prescribed</th>
<th>Prescribed with external verification (e.g. GP, drug service)</th>
<th>Prescribed without external verification (e.g. GP, drug service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
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<td></td>
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<tr>
<td>Diabetes</td>
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<td></td>
<td></td>
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<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Heart problems</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High blood pressure</td>
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<td></td>
<td></td>
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<tr>
<td>Substance use withdrawal</td>
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<tr>
<td>Psychosis</td>
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<tr>
<td>Depression</td>
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<td></td>
<td></td>
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<tr>
<td>Anxiety disorders</td>
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</tbody>
</table>

29. When prisoners report at reception that they are currently prescribed medication, within what time period does your establishment require that initial contact is made with outside services (e.g. GPs) to verify that information? (Tick one box)
   - Within 3 working days of reception
   - Within 3 working days of reception
   - Within 3 weeks of reception
   - There is no defined time period set in my establishment
   - Other (please specify)

30. For prisoners in receipt of prescribed medication immediately prior to custody, in which cases are their medications reviewed once in custody? (Tick one box)
   - In all cases
   - In cases where verification of medication with outside services has not been possible
   - In cases where there is a clinical need to review medication
   - Other (please specify)

31. Please use the box below if you have any further comments or suggestions for improvement regarding protocols for the verification and prescription of medication following reception.
3. MEDICATION IN POSSESSION

32. Do you have in-possession medication within your establishment?
- Yes (PLEASE SEND A COPY OF POLICY)
- No, PLEASE PROCEED TO QUESTION 45

33. Who contributed to the development of the policy of in-possession medication?
(Tick all that apply)
- Inpatients
- Doctors
- Pharmacists
- Nurses
- Security staff
- Other (please specify)

34. Do you have a system for reporting medication errors/ adverse incidents within your establishment?
- Yes (PLEASE SEND A COPY OF POLICY)
- No

35. Do you have a structured method for assessing prisoners suitability to receive medication in-possession?
- Yes (PLEASE SEND A COPY OF POLICY/RISK ASSESSMENT TOOL)
- No

36. Does your establishment have a list of medication that can NOT be given in-possession?
- Yes (PLEASE SEND A COPY OF THE LIST)
- No

37. Do you routinely supply medication information to patients within your establishment, e.g. patient information leaflets?
- Yes
- No

38. Do patients sign a contract before receiving medication in-possession?
- Yes (PLEASE SEND CONTRACT)
- No

39. How often is in-possession medication reviewed? (Tick all that apply)
- Year
- Kit within a specified time-frame, varies
- Dependent upon clinical factors
- Independent upon environmental changes/ patient’s needs
- Routinely (Please state routine intervals)

40. Do you provide specific storage facilities for patients with in-possession medication within your establishment?
- Yes
- No

41. If answered yes, which of the following do you provide?

<table>
<thead>
<tr>
<th>Facility</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fridge</td>
<td></td>
<td></td>
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<tr>
<td>Over plastic boxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinal</td>
<td></td>
<td></td>
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<tr>
<td>Box</td>
<td></td>
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</tr>
<tr>
<td>Other (please specify)</td>
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</tbody>
</table>
42. Are patients normally in receipt of in-possession medications allowed it on their person whilst away from the prison e.g. being transferred to another establishment or to a court appearance?

- Yes
- No
- Depends (please specify)

43. When do you carry out the risk assessment for in-possession medication? (Tick one box)

- Initial reception
- Follow up screen
- When new medication is prescribed
- Not routinely done
- Other (please specify)

44. Who usually carries out the risk assessment for in-possession medication? (Tick all that apply)

- Qualified nursing staff
- Non-nurse qualified healthcare staff e.g. Healthcare assistant, Healthcare officers etc.
- Pharmacists
- Doctors
- Other (please specify)

45. Does a Drug and Therapeutic Committee monitor prescribing activity in your establishment? (Tick one box)

- Yes (VOS)
- Yes (Prison)
- Yes (Other)
- No

46. Who provides the pharmacy and related services to your establishment?

- Create pharmacy
- SendRef to another prison
- Contracted by Local NHS Trust
- Contracted to Community pharmacy
- No pharmacist input
- Other (please specify)

47. Where is medication usually administered to patients within your establishment?

- Prisoners seen health care centres
- Prisoners seen in prison
- Prisoners seen in clinic
- Medication is administered at prison
- Other (please specify)
48. At what fixed time(s) is medication administered in your establishment?

<table>
<thead>
<tr>
<th>Time</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
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<tr>
<td>Lunch time</td>
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<td>Dinner time</td>
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<tr>
<td>Evening</td>
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<tr>
<td>Other (please specify)</td>
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<td></td>
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</tbody>
</table>

49. At what times are sleeping tablets and night time medication administered in your establishment?

- Before 8pm
- Between 8pm and 9pm
- After 9pm
- Other (please specify)

50. Are there any barriers to implementing in-possession medication which you have experienced in your establishment? e.g. conflict between clinical and security concerns/requirements (Please provide details)
Appendix 2: Interview topic guides

a) Staff

1. Introduction and greeting
   • explain interview format
   • remind of confidentiality arrangements

2. How are you making in-possession medication work within your establishment?

3. What is the risk assessment process within your establishment?

4. How accurate do you feel the risk assessment process is?

5. Do you think any changes need to be implemented regarding the risk assessment process?

6. What are the positive aspects of in-possession medication?
   • What are the clinical benefits
   • What are the security benefits

7. What are the negative aspects of in-possession medication?
   • What are the clinical concerns
   • What are the security concerns?

8. How do you judge a person to be in receipt of in-possession medication?
   • Is a risk assessment tool used?
   • Does staff opinion play a part in the decision making process?

9. Do we need to monitor patients who self medicate?
b) Prisoners

1. Introduction and greeting
   • explain interview format
   • remind of confidentiality arrangements

2. Do you have any prescribed medication in-possession?

   **If prescribed in-possession medication**

3. Were you given any leaflets or told about having your medication in-possession?

4. Did you sign a contract with rules about being responsible for your medication?
   • Did you understand this?

5. Do you feel you should in-possession of your own medication?

6. What are the benefits of in-possession medication?
   • In your experience or generally

7. What problems are there with in-possession medication?
   • In your experience or generally

8. Do you feel you can adequately store and look after your medication?
   • Do you have the facilities to do so?

9. What are your experiences of in-possession medication here and at other establishments?
   • (Good/Bad)

   **No prescribed medication**

10. Were you asked any questions about having your medication in-possession?
    • (to see if you are responsible)

11. What are your experiences of having your medication supervised?

12. Do you know why your medication is supervised?

13. Have you had any problems with having your medication supervised?
    • E.g. getting to healthcare on time

14. Do you feel you should be in-possession of your own medication?

15. Have you ever had experience of in-possession medication here or at other establishments?
    • Good or bad experiences
Appendix 3: Participant information sheets

a) Staff

The University of Manchester

An evaluation of in-possession medication procedures

Introduction

My name is ______________, I am a researcher working at the University of Manchester, Department of Psychiatry. At the moment we are working on a project to evaluate current procedures for in-possession medication for prisoners (i.e. that prescribed by a doctor or trained nurse, not including illicit substances).

Why is this study important?

A recent review of pharmacy services for prisoners showed wide variation across the prison estate over the proportion of prisoners for whom prescribed medication is supervised and given in-possession (i.e. the prisoner is responsible for his/her own medication). The review also highlighted differences in policies and risk assessments for in-possession, but acknowledged that, as a matter principle, in-possession medication should be regarded as the normal method of supply. We want to know more about how each prison manages prisoners who need regular prescribed medication.

What will I have to do if I take part?

If you agree to take part in the study, I will interview you about your experience of working with in-possession medication, and how this could be improved. The type of questions asked will depend on your job role but may include the following; what policies are there regarding in-possession medication within your establishment? What are the pharmacy services available in your establishment? What are the current methods for dispensing/administration of medication? What is the system for reporting adverse incident/medication errors within your establishment? This will take around an hour of your time. I will ask to record the interview using a Dictaphone, and will ask for your permission to use anonymous direct quotes when we report the results.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your professional role or prospects within this role will not be affected.

If I agree to take part what happens to the information?

All the information you give us will be confidential and used for the purposes of this study only. The information will be used in a way that will not allow you to be identified individually.

What do I do now?

• Think about the information on this sheet and ask me about anything that you are not sure about. If you agree to take part, we will go ahead.
b) Prisoners

The University of Manchester

An evaluation of in-possession medication procedures

Introduction

My name is ____________, I am a researcher working at the University of Manchester, Department of Psychiatry. At the moment we are working on a project that will look at what happens to prisoners who need to take regular medication (that is, prescribed by a doctor or trained nurse, not including any illegal drugs).

Why is this study important?

A review of medication services for prisoners said that there were great differences in how prescribed medication was given to prisoners across different prisons. Sometimes prescribed medication is taken under supervision by health care staff, and sometimes it is given ‘in-possession’. This means, the medication is given to prisoners and it is their responsibility to look after and take it themselves. We are doing this study to find out what your views are of how well this prison manages prisoners who need to take regular prescribed medication, and to see if services need to be improved for your benefit.

What will I have to do if I take part?

If you agree to take part in the study, you will be involved in an individual interview. During this interview I will first ask you about your experience of prescribed in-possession medication, including questions about what prescribed medication you are on, where you keep it, how you feel about keeping your own prescribed medication, and what problems you may have with looking after your prescribed medication. I will then ask how you think this could be improved.

I will ask you for permission to tape the interview using a voice recorder. I will also ask for your permission to use things that you say in the interview in the final report. Your name or any identifiable information will not be printed. I will also ask for your consent to look at your prison medical records.

How long will this take?

This will take around 45 minutes of your time.

Do I have to take part?

No, taking part is voluntary, and you do not have to do it. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your legal and parole rights and your access to medical care will not be affected.
If I agree to take part what happens to the information?

All the information you give us from the interview and from your medical records is confidential and will be used for this study only. The information will be used in a way that will not allow you to be identified individually. The only exception to this is if, after the interview, we feel your health or safety, or that of others around you is at immediate risk because of something you have told us about how you are feeling. In that case, we will have to pass that information on to the prison healthcare staff, so that they can help you further.

What do I do now?

Think about the information on this sheet and ask me about anything that you are not sure about. You have 3 days to decide if you want to take part. If you agree to take part, we will go ahead.

If I need to see someone about the research after I have taken part who can I contact?

If, after taking part in the research, you want further information or have any more questions about the study, tell your personal officer who will then contact me and I will come back to see you.

But if after taking part, you become upset and need help immediately to deal with your feelings without hurting yourself, it is very important that you talk to someone straight away.

Any member of staff in the prison will be able to help you; all you need to do is speak to someone.

Please do this as soon as you start feeling upset, it will help
Appendix 4: Thematic network summarising key interview themes

**IN-POSSESSION MEDICATION**

**Benefits**
- Reduced workload
- Better use of time
- Better control of pharmacy stock
- Increased responsibility
- Equivalence with community
- Fewer patients at hatch
- Less time waiting/queuing

**Disadvantages**
- Risk of harm to prisoners
- Security risks
- Drug misuse
- Reduced compliance
- Trading
- Bullying
- Trading information
- Patient advice
- Relationship building
- Cell searches

**Barriers**
- Prison systems
- Staff attitudes
- Lack of clinical info systems
- Lack of storage facilities
- Transient populations
- Poor communication between health & security staff

**Medication factors**
- History of compliance
- Self-harm risk
- Risks of non-compliance
- Trading value
- Side effects
- Formularies

**Form**
- Structured vs unstructured
- Formal vs informal

**Risk assessment**
- GP opening hours
- Late arrival of prisoners
- Prisoner mental/physical state
- Prisoner systems
- Staff attitudes

**Medication verification**
- Better clinical info systems

**Improvements**
- Better use of time
- Reduced workload
- Better control of pharmacy stock
- Increased responsibility
- Equivalence with community
- Fewer patients at hatch
- Less time waiting/queuing

**Patients**
- Equivalence with community
- Fewer patients at hatch
- Less time waiting/queuing

**Organisational**
- Better use of time
- Reduced workload
- Better control of pharmacy stock
- Increased responsibility
- Equivalence with community
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