NHS England

Health and Justice mental health services:

Safer use of mental health medicines

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1 Executive summary

NHS England directly commissions services for people in secure environments including prisons, young offender institutions, immigration removal centres and secure training centres. Mental health services are either commissioned directly by NHS England or are subcontracted by the primary healthcare provider. Although directed at health and justice commissioned services, the content may also have relevance for secure mental settings.

The Five Year Forward View for Mental Health and several publications, including NICE Guidelines for improving the physical and mental health of people in prison (NG57 and NG66) support improvement in mental healthcare and medicines optimisation in health and justice settings. There are challenges with optimising mental health medicines for people in these settings, especially as many people have substance misuse or pain management needs and there is a high prevalence of people with personality disorder. The resulting polypharmacy and potential for care fragmentation creates a backdrop of medication safety risk.

This document is aimed at commissioners, provider organisations delivering healthcare and mental health services, and the prescribers and healthcare workforce within them who are involved in embedding the medicines optimisation pathways into care. The document purpose is to guide improvements in practice and advises about specific issues including:

- Where medication fits into a person centred recovery oriented approach to care and wellness
- Clarification of prescribing responsibility for initiating, continuing, reviewing or repeat prescribing of mental health medicines by specialist mental health prescribers versus primary care prescribers.
- Medicines risks and governance infrastructure for mental health for people in prison: there is increasing evidence of abuse or diversion of some mental health medicines in prisons.
- A multidisciplinary, collaborative and holistic approach to medicines optimisation and information sharing between generalist and specialist clinicians, the pharmacy team and the person.

The document provides a background to prescribing and mental health medicines in secure environments with some common principles that apply throughout the medicines optimisation pathway, and more detailed information within the pathway to support safer practice.

Secure mental health units are also directly commissioned by NHS England, but they are out of scope of this briefing. The definition of secure environments in this briefing includes prisons, young offender institutes, immigration removal centres and secure training centres only.

2 Background

The Five Year Forward View for Mental Health has made an unarguable case for transforming mental health care in England and the implementation guide[1] is inclusive of people being cared for within health and justice settings. Running alongside and integral to these reforms is the promotion of mental health awareness and wellbeing encapsulated in programmes such as Making Every Contact Count and Five Ways to Mental Wellbeing which promote the non-pharmacological aspects of recovery

Medicines often still form an integral part of mental health care pathways. In health and justice settings people commonly experience complex health problems, with long term conditions such as diabetes, cardiovascular or respiratory disease, as well as chronic pain and substance misuse. These create additional challenges for people and clinicians with polypharmacy and patient safety. The principles of medicines optimisation published by the Royal Pharmaceutical Society in 2013 and shown in Appendix 1, provide the foundation for improving outcomes with medicines, including mental health medicines and provide the framework for the content of this document.

In 2016 and early 2017 there has been an increase in deaths in prisons. Clinical reviews and Prison and Probation Ombudsman reports and thematic reviews into these deaths and in particular those categorised as self-inflicted have included recommendations about the safe use and continuity of mental health medicines. Common themes include issues with:

- Delays in continuing mental health medicines prescribed in the community
- Lack of clarity about the role of general practitioners versus mental health clinicians with initiating, repeating, monitoring and reviewing mental health medicines
- Poor documentation about the indication or diagnoses that are the basis for the prescribing of mental health medicines
- Poor information sharing and collaboration between clinicians for complex cases that include polypharmacy with mental health medicines

Since 2015 there has been publication of national standards and guidance that support improvement in mental healthcare and medicines optimisation in health and justice settings. Four key publications are:

- Standards for Prison Mental Health Services- Quality Network for Prison Mental Health Services and Royal College of Psychiatrists
- NICE Guidelines for Improving the Physical Health of People in Prison (NG57)
- NICE Guidelines for Mental health of Adults in contact with the Criminal Justice System (NG66)
- Professional Standards for optimising medicines for people in secure environments- Royal Pharmaceutical Society

This document aims to raise awareness and influence commissioners, providers and clinicians caring for people in secure environments to guide improvements in the safe use of mental health medicines.

[1] NHS England, Implementing the Five Year Forward View for Mental Health *(Link)*

3 Over-arching principles

Mental health services in prison are commissioned on the basis that care is person centred and recovery focussed taking into account the appropriate place of mental health medicines in someone's journey to recovery and wellbeing
Principles of good practice exist that improve medicines safety and the person's experience across the whole mental health care pathway and across the sections in this briefing:

1. There is proactive collaboration, multidisciplinary and integrated working between mental health, general medical, substance misuse clinicians, the pharmacy team, wider healthcare and prison teams.
2. Care, including psychiatric, psychological and psychosocial interventions ,is underpinned by
    - medicines and mental health legislation
    - national clinical guidelines and professional and regulatory standards
3. Shared care between general practice and mental health clinicians supported by the pharmacy team within the secure environment shows clearly defined responsibilities for prescribing, monitoring and mechanisms for seeking timely advice from mental health specialists.
4. People in secure environments receive equivalent care to that available in the community. This includes access to specialist mental health medicines such as clozapine. Due to the challenges for delivering safe care to people in custody, specific local induction training to support clinicians new to secure environments is advised.
5. Use of the health and justice clinical IT system (SystmOne) as the master record for the person so that:
    - services are delivered that embrace the NHS plans for NHS Digital Technology: This includes a digital medicines programme
    - all mental health medicines are prescribed and their administration recorded on SystmOne contemporaneously in a single care record including depot injections
    - mental health prescribers, including in-reach specialists, prescribe directly onto SystmOne, phasing out the use of letters or tasks to GPs in the secure environment asking them to prescribe.
    - The system is used so safety or clinical concerns are visible to all users
6. The amount of medicines provided in-possession is tailored to individual need in line with collaboratively developed local in-possession policies and risk assessments.
7. Enabling self-administration of mental health medicines as mental health improves or there is other significant change: the quantity prescribed or provided in-possession can be increased or reduced to align with clinical assessment and reviews at different points within the person's care.
8. Supporting and informing peoples with clear information about which medicines will be prescribed for them or are being changed, with a plan to review this once medicines have been confirmed or outcomes assessed. This is essential for managing their expectations and anxiety especially for people with learning disabilities.

9. Involving people in discussions about medication being initiated for their treatment so they can make an informed choice, in partnership about what particular medicine is prescribed
10. Active contribution to Assessment Care in Custody & Teamwork (ACCT) system that
    - clarifies who is best placed to be involved in the process including taking part in multi-disciplinary reviews
    - provides healthcare and mental health staff with clearer information on their roles

4 Prescribing medicines for mental health

4.1 Continuing mental health medicines on admission to H&J

Adequate and timely risk assessment and subsequent prescribing decisions for continuing mental health medicines when a person is first admitted to custody are a key challenge for prescribers, but has also been a factor in the self-harm and death of prisoners.

The first reception assessment records medicines that the person is taking, based on verbal information from the person, any labelled medicines within the person's property and clinical information from a previous custodial stay (for example from the police custody Person Escort Record).

Additional development and implementation of processes that provide prompt access to external information about current prescribed mental health medicines should be prioritised, especially during office hours, for example using information from the:

- Summary Care Record (SCR)
- community GP practice
- secondary care mental health records
- community pharmacy patient medication records

It is acknowledged that there is a significant challenge for prescribers when a person is admitted to prison from the community rather than from another prison or other residential secure environment. This is because the clinical IT system (TPP SystmOne- H&J) is continuous as people are moved between these settings, with a complete record of all current and previously prescribed and administered medicines during the person's time in custody. Validation and continuation of prescribed medicines for people transferred from another secure environment is therefore easier than for those admitted from the community.

First night prescribers (i.e. those usually prescribing within the first 24 hours after admission) are usually general healthcare clinicians and/or substance misuse specialists. In some secure environments, a specialist psychiatrist or nurse are available to provide advice for first night prescribing and their expertise can be sought where there are concerns about omitting or continuing doses of mental health medicines.

First night prescribers use Good Practice in Prescribing to assess the person and the reception screen outcomes to decide whether or not:

- it is safe to continue the mental health medicines straight away, allowing access to doses that are due taking into account polypharmacy and presenting symptoms including signs of intoxication and drowsiness.
- To complete additional urinalysis to confirm the presence of prescribed or illicit medicines that could influence the safety of supplying mental health medicines
- to prescribe a shorter interim supply of the medicines to reflect the expected period until a specialist mental health assessment or outcomes of a medicines reconciliation inform further medicines continuation.
- to omit doses of the mental health medicines pending verification of community or other external prescribing and outcomes from a medicines reconciliation
- whether specific medicines require dose tapering rather than omission due to the potential for adverse effects if the medicine is suddenly stopped.
- to refer the person to a mental health specialist before continuing to prescribe

It is important to note that first night prescribers are under no obligation to continue a medicine prescribed by a previous clinician. Prescribers in prison can evaluate current medicines and adjust treatment where their clinical judgement concludes this is appropriate.

The decision made will depend on the individual and the outcomes from the first night assessment and the availability and timing of specialist assessment. If not continued by the prescriber, then information to the person about this **with reassurance that their need for the medicine is being actively reviewed with a timescale for the next steps are crucial to minimise their anxiety and possible self-harm**.

Throughout this process continuity of care and risks vs benefits of prescribing need to be weighed up. The decision whether or not to prescribe and any mitigation of consequences must be carefully documented and communicated /handed over to staff who may be left with managing both intended and unintended consequences of a clinical decision made earlier

The following points may support prescribers in making the decision for first night prescribing of mental health medicines:

a) The physical health in prisons NICE guideline NG57 (2016) includes antipsychotics in the list of critical medicines where omitted doses could be harmful.
b) Any omission of antipsychotics, especially where the need and adherence to the medicine is likely, will need to be weighed up against the possible harm from omitted doses and clearly documented.
c) Specific psychotropic medicines at high risk of harm due to omission are clozapine and lithium- prompt communication is needed to access the information to inform safe and timely continuation of these medicines.
d) Antidepressants are not listed as critical medicines for immediate continuation. Doses could be omitted pending medicines reconciliation or mental health review however consideration will still need to be given to the anxiety the person may experience in doing so and the risk of discontinuation reactions.

e) Hypnotics, anxiolytics and mood stabilisers (such as gabapentin, pregabalin and carbamazepine), are not included in the list of critical medicines, but continuation may be needed to treat mental health indications due to the presenting symptoms, duration of treatment or vulnerability of the individual person.
f) Many people in prison who are prescribed antipsychotics or mirtazapine have a history of substance misuse. This history and any evidence of intoxication may require adjustments in the care plan or deferral of prescribing
g) Complex cases of polypharmacy with mental health, analgesics and other physical health medicines, mood stabilisers and substance misuse medicines need careful consideration of risks of polypharmacy – prescribers need to
    - take account of all medicines being taken
    - prioritise medicines continued on safety grounds until medicines reconciliation is completed, the full medical history and diagnoses are confirmed, or decisions supported via a multidisciplinary case review.
h) Where there is doubt about the pervious adherence to regular doses of mental health medicines, the risks posed by continuing previously prescribed doses whether this is provided in-possession or not may outweigh the risks of omitting the dose.
i) Where this doubt or a lack of information about previous diagnosis for mental health medicines, referral or additional clinical assessments should be arranged to confirm the diagnosis and inform the next medication review.
j) Where there is concern for an individual's safety and self-harm with medicines, an initial decision to provide the mental health medicines not in-possession can be taken but with a clear inclusion of an in-possession review as part of future medication reviews and clinical assessments.

Good Practice Point

Our weekly MDT meeting is attended by the GP, psychiatrist, primary and secondary mental health & substance misuse teams. It lasts 30-60 mins.

Any of us can list a patient for the meeting and raise our concerns. In theory the meeting is for when a patient crosses over more than one "group" and so needs joined up work. It is also used to discuss "problem" patients – with "problem" being any aspect of their care or behaviour.

Prison GP, HMP Haverigg

4.2 Initiating new mental health medicines

People in prison and other secure environments may develop mental health needs or the symptoms of their current mental health problems may change. Against the backdrop of equivalence in care for people in custody with people in the community, there are some key elements of mental health service provision in secure environments that require adjustment to support medicines optimisation:

- Mental health clinicians provide consultations and support for people inside the secure environment i.e. an in-reach approach
- The shared, single clinical record in secure environments enables the co-morbidities such as physical health and substance misuse needs for people also suffering from mental illness to be managed holistically and collaboratively between services and clinicians.
- Specific mental health medicines are known to be highly sought after by people in prison for diversion or abuse. This means local formularies and in-possession policies are adjusted to take account of these risks.

To support the safe use of mental health medicines in secure environments that takes account of the above factors the following recommended practice for initiating new mental health services are advised:

4.2.1 Who should prescribe initial prescriptions?

Psychiatrists or non-medical mental health prescribers should initiate all antipsychotics and mood stabilising agents.

This is in line with NICE guidance which recommends early referral for specialist assessment[2]. In health and justice mental health services, the specialists provide mental health consultations in the prison and thus have access to the health and justice clinical IT system. To maximise efficiency and safety of prescribing the specialist prescriber should

- prescribe directly onto the system and issue and sign the initial prescription. The use of “please prescribe” instructions for initial prescriptions should be phased out.
- as part of the prescribing process, view and review the in-possession status for the person and also follow local policies for the in-possession status of specific mental health medicines.
- set up the repeat template where the antipsychotic is able to be repeated until the next consultation or review. This function is integrated within the prescribing process on H&J SystmOne and can provide clear information about when the prescription should be reviewed
- prescribe and set up the repeat template to cover supplies until the next planned clinical review

Prescribers should discuss treatment with the person providing information on treatment choices, how to take the medication, potential side effects, and any monitoring requirements.

[2] NICE Psychosis and schizophrenia in adults: prevention and management Clinical guideline Published: 12 February 2014 www.nice.org.uk/guidance/cg178

Good Practice Point

The mental health team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements

NICE Psychosis and schizophrenia in adults: prevention and management CG 178 2014

Antidepressants for mild to moderate depression and hypnotics can be initiated by non-specialists. Clear and prompt referral to specialists should be in place for severe symptoms.

Where a clinical decision is taken to initiate antidepressants, the person should be monitored for the appearance of suicidal ideation, self-harm or hostility. Specific guidance published by NICE to monitor children and adolescents can be found here. Guidance for younger adults can be found here.

4.2.2 Underpinning practice for safer prescribing

National clinical guidelines for the management of mental illnesses and NICE Technology Appraisals for mental health medicines underpin the management of mental illness for people in custody.

A documented indication for each mental health medicine prescribed and mental health care plan should be recorded by the lead clinician. This facilitates ongoing care by other clinicians both within and external to the H&J setting.

Good Practice Point

Record the diagnosis in a place that makes it clearly visible in the prison clinical record. For example in SystmOne, the diagnosis can be recorded as a "problem" which links subsequent consultations to the diagnosis

Prison GP HMP Haverigg

Prescribing should be in line with licenced indications and dose ranges and within national clinical guidelines. Deviation from this should be clearly justified and documented in the clinical record by the prescriber to support continuity of care. The off-label use of low-dose antidepressants for insomnia and sedation e.g. mirtazapine, should be avoided as this leads to increased risk of diversion and abuse.

Consider using short and acute (i.e. not repeat) prescriptions for new mental health medicines. These shorter duration prescriptions (e.g. 7-14 day rather than 28-day prescriptions) can cover dose titration and can be aligned to more frequent reviews of care until stability is achieved.

The clinical indication and relative safety versus benefit of each medicine should be considered, linked to the person's in-possession (IP) assessment outcomes or IP status of the medicine in the prison. Prescribers should take account of the history and risks of substance misuse by people seeking prescriptions for mental health medicines.

The risk of using a medicine needs to look ahead to release and the possible change from non - IP to monthly GP scripts in the community which are self-administered. This is especially needed for remand prisoners or prisoners serving sentences of less than 6 months. An alternative choice of medicine may be needed where IP status of the mental health medicine in prison is unlikely to change throughout the stay in custody due to individual risks.

To support repeat prescribing and shared management of the person by other clinicians, key information needed about initiated mental health medicines includes:

- Care plan associated with the diagnosis and full details and doses for the medicines prescribed
- Details of any planned dose changes within the plan
- Physical health and where appropriate therapeutic drug monitoring plans for example clozapine and lithium levels
- When the next mental health review will take place
- Any trigger symptoms that require contact with the mental health team prior to the planned review

4.2.3 Diversion or abuse of mental health medicines

In health and justice settings, the risks of harm from abuse and diversion of medicines have been highlighted in national reports and clinical guidelines[3] [4]. There are several mechanisms used to reduce this risk.

- Formulary choices: Certain mental health medicines such as pregabalin, gabapentin, mirtazapine, quetiapine and hypnotics and some analgesics are known to be sought after and abused. Providers can adjust formulary choices to enable less diverted alternatives to be chosen that is likely to result in the same clinical outcome.
- IP policies and assessment: In all health and justice settings, people are assessed for their suitability and safety to have their medicines in their possession for self-administration. The amounts held in-possession usually ranges from 7-28 days. In addition providers can restrict specific medicines to be held in-possession by everyone for less than 28 days or can restrict it to not in possession (i.e. supervision of all doses). It is essential that the mental health team contribute to the healthcare provider's IP policy and also actively review and adjust the IP status of individuals as their mental health changes.
- Adherence checks: Adherence checks completed during routine medication or clinical reviews can highlight whether omitted doses of mental health medicines or possible abuse or diversion has contributed to the person's

[3] RCGPSEG 2011 "Safer Prescribing in prisons" Link
[4] HMIP 2015 "Changing patterns of substance misuse in adult prisons and service" Link

outcomes. The electronic medication chart can be viewed to facilitate this check as:
    - Missed doses of mental health medicines will be visible
    - Frequency of prescriptions can identify incidents of over or under ordering of repeat prescriptions
- Identifying people more at risk of bullying, for example people with learning disabilities, dementia, or other identified vulnerability
- Identifying people more at risk of trading or diverting medication, for example those with a previous history of doing so.

Some secure environments collaborate with security teams to deliver un-announced, random checks of medicines in-possession to identify possible non-adherence. Where non-adherence to mental health medicines is identified, the person is referred for a mental health review.

Good Practice Point

Adherence checks are completed monthly on an entire wing. The preparation for checks is essential and although time intensive is invaluable. It is also essential that patients have a signed medication compact as this is used when there is a non-adherence and supports adjudication. Patients that are non-adherent are issued with a letter advising them of the next steps - all patients have a GP medications review and are placed on report by the prison.

This is very much a joint venture with high prison support during spot checks so that multiple checks can take place at one time with the prison team dealing with the discipline element- this makes the entire check quick and is not time intensive.

In terms of reviewing medications following a failed check a number of factors are considered: the drug, the dose, the patient's general well-being, mental health and other factors. There really isn't one rule that fits all but as a team we have developed our own processes so there is consistency. Initially we saw an increase in complaints and legal representations but with a consistent robust approach these are now negligible. Where we have had direct complaints to NHS England and where investigated and reviewed independently no complaint has been upheld.

Head of Healthcare HMP Highpoint

Where diversion or abuse of mental health medicines is identified, this would trigger a mental health and medication review. A collaborative approach by the mental health team with other clinicians is recommended to manage these incidents, especially where other medicines have been diverted or abused. This will encourage a united approach to agree any changes to the medicines prescribed, with reference to the in-possession policy and incident reporting and handling.

5 Repeat prescriptions and medication review

Repeat prescribing and medication review responsibilities for individual people taking mental health medicines needs to be part of formal medicines policies and service delivery models for each prison developed in partnership by all providers. This avoids uncertainty about which clinician undertakes ongoing and review of treatment which could lead to omissions in care or harm.

5.1 Repeat prescribing

Repeat prescribing for all repeatable medicines in H&J settings should be underpinned by robust procedures which

- Trigger requests for and generation of the repeat prescription in a timeframe that allows the medicines to be dispensed and supplied to the person before their current supply runs out.
- Identify and refer any safety issues that indicate a repeat prescription should not be written and a review completed instead
- Ensures the prescriber has access to all the information needed to safely generate and sign the repeat prescription

GPs can issue repeat prescriptions for mental health medicines within shared care arrangements that also operate nationally or within local area prescribing policies. Information needed for the GP to issue repeat prescriptions and share care needs to include all the details about the mental health medicines needed plus any therapeutic drug monitoring or physical health monitoring needs and who is responsible for arranging these. This is particularly important for high risk medicines such as clozapine and lithium.

Good Practice Point

Clozapine: HMP Bedford teams use a standard operating procedure when a prisoner is prescribed clozapine. This is underpinned by a multidisciplinary approach described below:

"*For the last patient on clozapine, the mental health team were aware of the patient coming in and a plan was discussed with the pharmacist and the mental health team for management. They had also assigned a member of staff who was the main liaison nurse for the patient. We confirmed our roles in the management and planned to make sure there were no gaps. We in the pharmacy would liaise with the MH Team and staff who perform bloods and make sure the patient has the blood test.*"

Lead pharmacist HMP Bedford

Where local primary care prescribing policies or national specialised commissioning policies require a medicine to be prescribed and supplied via the specialist, then this should also be followed for people in secure environments. Where all prescriptions, including repeats, for a mental health medicine are prescribed by the specialist, then this should be clearly documented in the clinical record so that repeat prescribing

requests for these medicines are made to the right prescriber and in a timely manner that prevents delays or omitted doses. A timetable for clinical or medication review should be clearly documented and aligned with the number of repeat prescriptions that can be issued.

Evidence of missed doses during a repeat period (e.g. a month) should be taken into account by prescribers when prescribing the next prescription, with contact with the specialist for prompt advice in the event that several consecutive doses have been missed. Collaboration with pharmacy teams to identify missed doses could support this via an initial triage approach.

In the event that the GP is not willing to take clinical responsibility for prescribing repeat mental health medicines, and there are clear clinical safety reasons for this, for example the indication is unlicensed and its use is outside clinical guidelines, then prescribing responsibility would pass to the specialist prescriber.

5.2 Medication review

Review of treatment should be by the mental health specialist for antipsychotics and for people with mental health care plans that are led by the mental health team. A robust recall system is needed to underpin timeliness of reviews.

Reviews need to take into account

- the diagnosis and whether this continues to be appropriate
- other treatment/conditions that require medicines that could affect overall care and safety of mental health medicines (e.g. medicines for substance misuse or pain)
- information about behavioural concerns, medication incidents, medicines adherence and other information from and to prison staff. This enables a comprehensive view and support for care, as would be the case for family/carers for people treated in the community.
- therapeutic drug monitoring and physical health monitoring that reflects national guidance such as the LESTER framework.

Good Practice Point: Shared care

GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease.

NICE Psychosis and schizophrenia in adults: prevention and management CG178 2014

Good practice would also see enhanced record entries detailing the person-centred goals of the treatment so the medication review progress and impact of the mental health medicine can be assessed holistically.
Timing of reviews vary between remand versus sentenced prisoners- with a maximum of 3 months suggested between reviews for remand prisoners and a 6 month time lapse between reviews for sentenced prisoners.

The use of a medicines use review[5] by pharmacy teams can be considered to support people taking mental health medicines, especially where there is polypharmacy.

5.3 Managing people with complex needs

People in secure environments often have additional co-morbidities along with their mental health needs. The common examples include substance misuse, physical health co-morbidities, long term conditions and persistent/chronic pain. These can result in polypharmacy with examples such as co-prescription of opioids for analgesia or opioid substitution therapy for dependency, often needed with antipsychotics and antidepressants. Particular risks exist where multiple sedating medicines are prescribed or medicines that prolong the QT interval are prescribed with certain opioids.

In order to effectively manage or reduce polypharmacy, careful consideration and proactive, regular collaboration is needed between general medicine, substance misuse, pharmacists, mental health practitioners and the person (who has capacity). This helps to avoid adverse effects resulting from the interaction between mental health and other medicines and can support reduction in polypharmacy. Increased frequency of screening may be needed where there is co-morbid obesity, diabetes or smoking.

Inappropriate prescribing or prescribing that is in place to treat the clinician's anxiety rather than the person should be reduced. This is a particular challenge where the person is demanding medicines and uses a strategy of requesting these from the different prescribers managing their health. Multidisciplinary case reviews and clear documentation of medicines being changed or initiated for these complex cases will help resolve these risks and provide a unified plan for reference by all clinicians involved in the person's care.

People with complex needs and or in the older age bracket may have fluctuating health and wellbeing or develop a condition leading to a sudden deterioration and to problems emerging with renal and liver function that can result in dose toxicity of mental health medicines.

[5] PSNC : Medicines Use Reviews Link

Good Practice Point: Communication and care co-ordination

- ✓ Ensure that people with complex health and social care needs have a lead care coordinator responsible for managing their care. Ensure that the person and all healthcare and prison staff know who this is.
- ✓ Review people in prison with complex health and social care needs. Ensure that if a person is supported by a multidisciplinary team, the teams meet regularly to plan and coordinate ongoing management. These should be facilitated by primary care.

Recommended by NICE Physical health of people in prison NG57 2016

The increasing older population and improved identification of people with learning disabilities can result in people needing additional support to manage their medicines. Pharmacy teams are well-placed to provide adherence support via a range of interventions e.g. medicines optimisation review, reminder charts or compliance aids.

All clinicians should be aware of national guidance about the appropriate use of antipsychotics and sedating medicines for people with dementia and with learning disabilities. There should be a proactive and thoughtful confirmation of the need for these medicines as part of medication reviews.

6 Continuation of medicines on release or transfer

Communication about ongoing treatment should happen for people taking mental health medicines who are released or transferred to another establishment. Ideally communication should use the clinical record and templates/reports generated from it thus providing consistency for all people who leave who need continued, uninterrupted access to mental health medicines.

A core content of information about medicines as part of a comprehensive discharge summary should be incorporated into local transfer or release planning arrangements, sent to the relevant agencies, organisations or clinicians wo will be delivering the person's care; for example, including medicines needs as part of electronic discharge summaries, incorporated into referral letters, or as part of documentation used on transfer to secure mental health units.

Transfer communications are opportunities to highlight the opportunity and good practice of undertaking a medication review to review a person's medicines use in the treatment and care setting of their new environment.

Good Practice Point:

NHS England are providing national clinical templates for release planning and information sharing at the point of release or transfer out of secure environments. Using these will enable core information to be shared with the relevant agencies and with clinicians who will continue the person's care. These templates align with national standards and guidance and include the requirement for a full list of medicines being taken and information about medicines that have been stopped or changed in line with national guidance

NHS England Health and Justice Clinical Reference Group

Release planning may need to involve support from probation services for the person to access ongoing care effectively. Communication for continuity of care is also needed where the person needs secondary care mental health services in the community

Appendix 2 shows the core information about medicines recommended by The Royal Pharmaceutical Society and Academy of Medical Royal Colleges.

Proactive engagement by clinicians delivering care in prisons with networks or formal groups such as area prescribing committees, CCG or mental health providers of community mental health services will help raise awareness of the needs of people transferred out of and into prisons.

7 Additional governance and safety considerations

7.1 Training for teams working in secure environments

The NICE guideline Mental health of adults in contact with the criminal justice system (NG66) 2017 includes four recommendations about training needed for staff working in the criminal justice system. In summary, these cover:

1. The purpose of the service being delivered and related services that staff will need to engage with, roles and responsibilities within teams, protocols and knowledge of legislative requirements to be followed
2. Attitudes of staff about mental health and how to improve communication skills
3. Provision of multidisciplinary and multi-agency training (as part of both induction training and continuing professional development) to increase consistency, understanding of ways of working, and promotion of positive working relationships for all staff who work in the criminal justice system across a range of mental health issues
4. Identifying clinical and operational risks, managing stress and managing patient safety incidents.

In addition to this training is needed for people new to working in secure environments about:

- The clinical and behavioural challenges of the custodial population and how to manage this by learning additional clinical assessment skills, and communication skills to support person-centred care and multidisciplinary working.
- The health needs and co-morbidities that are often interdependent and contribute to outcomes, anxiety and behaviour. For example the contribution of mental health to pain care and substance misuse.

This training is best provided locally across one or more secure environments in a locality thus enabling the development of local clinical networking and working relationships needed to facilitate effective multidisciplinary collaboration and communication.

Good Practice Point:

RCGP Substance Misuse and Associated Health (RCGP SMAH) provides training in the management of drug misuse and dependency with Level 1 and 2 training including modules on the management of patients with mental health co morbidities

RCGP Learning: Link

7.2 Reporting and management of medication safety incidents

Medication safety incidents with mental health medicines should be a priority within a patient safety reporting framework and culture within all teams. As for all medication incidents, providers need an integrated approach to incidents with mental health medicines that includes appropriate advice sought from local prescribers and national poisons information services and actions that result in sharing the learning and changes in practice that result in a reduction in risk of incidents re-occurring.

Examples of the type of incidents with mental health medicines include:

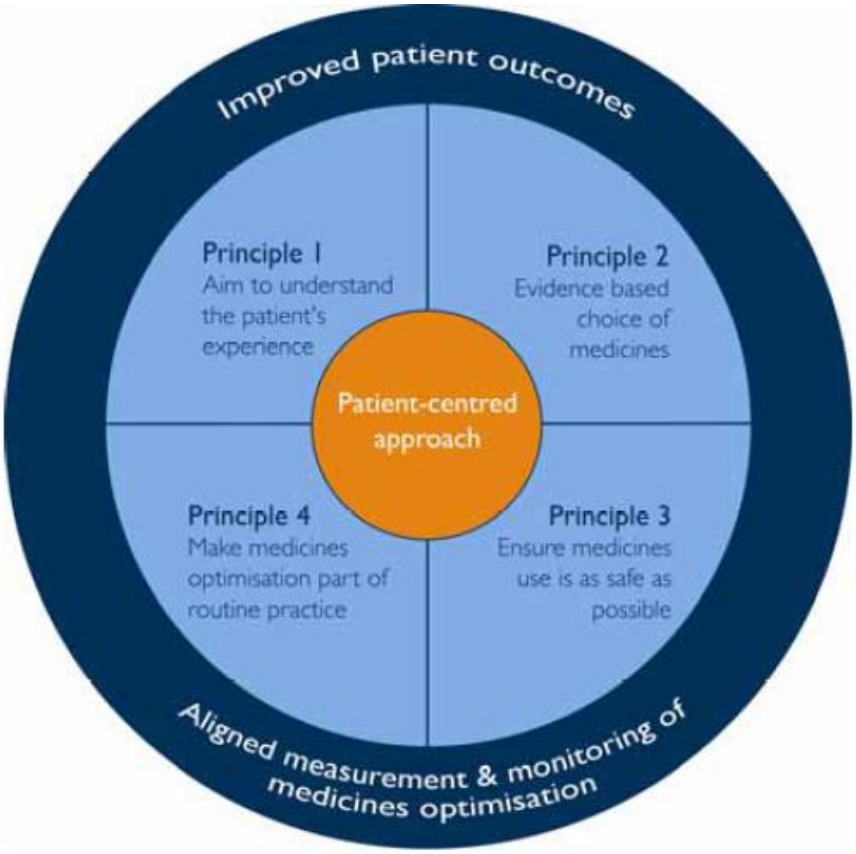
- Omitted or delayed doses resulting in a person's distress, clinical harm or challenging behaviour
- Diversion or illicit use of mental health medicines- antipsychotics, hypnotics, pregabalin and mirtazapine are commonly sought after or abused
- Interactions with novel psychoactive substances (NPS)
- Incidents resulting from a lack of therapeutic or physical health monitoring
- Prescription errors due to conflicting or incomplete information
- Medicines administration errors or near misses
- Errors in using the IT system when prescribing or administering medicines that result in near misses or actual dose errors.

Preventing harm can be achieved via prompt referral for medication or clinical review as people show deteriorating symptoms or where there are concerns about non-adherence.

Where diversion, bullying or illicit use of mental health medicines are suspected or identified, clear procedures for referral and collaboration resulting in clinical review are needed. Partnership with security and understanding of disciplinary actions should underpin a holistic approach to decision making about actions arising from these incidents including changes to mental health medicines. This should include follow up of the person to identify any subsequent risks of self-harm or mental health deterioration.

Providers should have access to a Medication Safety Officer in line with national guidance to support the identification, handling and prevention of medication safety incidents. Controlled Drugs Accountable Officers (CDAOs) within organisations, including NHS England CDAOs, can support improved safety and incident where Controlled Drugs are a factor in the safety of mental health medicines.

8 Appendix 1: Principles of Medicines Optimisation



Referenced from RPS: Medicines Optimisation: Helping patients to make the most from their medicines May 2013 Link

9 Appendix 2: Recommended core content for information about medicines on release or transfer

PATIENT DETAILS*	Last name, first name, date of birth, NHS number, patient address
GP DETAILS*	GP/Practice name
OTHER RELEVANT CONTACTS DEFINED BY THE PATIENT	For example: ■ Consultant name; Usual community pharmacist; Specialist nurse
ALLERGIES*	Allergies or adverse reactions to medicines ■ Causative medicine ■ Brief description of reaction ■ Probability of occurrence
MEDICATIONS*	Current medicines ■ Medicine – generic name and brand (where relevant) ■ Reason for medication (where known) ■ Form ■ Dose strength ■ Dose frequency/time ■ Route
MEDICATION CHANGES*	Medication started, stopped or dosage changed, and reason for change
MEDICATION RECOMMENDATIONS*	Allows for: ■ Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing, or changing medicines. ■ Requirements for adherence support, for example, compliance aids, prompts and packaging requirements. ■ Additional information about specific medicines, for example, brand name or Special product where bioavailability or formulation issues
INFORMATION GIVEN TO THE PATIENT AND/ OR AUTHORISED REPRESENTATIVE*	If additional information supplied to the patient/authorised representative on transfer. For example: ■ patient advised to visit community pharmacist post discharge for a medicines use review (MUR) ■ where capacity, sensory or language barriers, how all necessary support information has been given to authorised representative/carer
PERSON COMPLETING RECORD*	Name, time, date, job title Contact telephone number for queries Signature (if paper based)

Referenced from RPS: Keeping patients safe when they transfer between care providers –getting the medicines right. Good practice guidance for healthcare professions July 2011 Link