National Offender Management Service

HM PRISON SERVICE
Public Sector Prisons

WARREN HILL THERAPEUTIC COMMUNITY

ANNEX 9: MEDICATION POLICY

Policy for the Use of Medication in Prison Therapeutic Communities

This policy in respect of prescribed medication applies to those applicants for whom an abrupt termination of psychotropic medication would be deemed unsafe or unrealistic.

It also refers to those who may "relapse" or fail to manage difficult periods in therapy, thus holding them in TC treatment at a time when they may otherwise have opted to leave their community or been prevented from doing so by their medical/psychological condition.

1. Prescription and medication will be within the NICE guidelines except where a joint case for variation is made between the prescribing doctor and the therapy manager.

2. There is a commitment by the applicant to reduce his / her dependence on medication as soon as possible, and at least within six months of joining the host community.

3. Where a prescription is reinstated, there must be evidence by the prisoner that they have taken / are taking the medication on time. In practice this usually means that this must be witnessed.

4. Prescription should be for a therapeutic period – i.e. for as long as it takes for the drug to become effective and maintain efficacy. In some cases, should prescription be re-instigated, this may be for several months.

5. The prisoner must be willing to disclose to the community that they are taking medication and where appropriate discuss the effects and reasons in their group.

6. Addictive drugs such as valium or sleeping pills will not be prescribed apart from short courses of nytol (three days max), or in cases of severe pain, opiate based analgesia.

7. Prescriptions will only be provided following joint consultation between healthcare and the TC. Attempts by prisoners to obtain medication from healthcare independently will be seen as a choice to opt out of therapy in the TC. Neither the therapy manager nor healthcare should prescribe psychotropic medication to a TC prisoner unilaterally.

8. An appropriately worded release of confidentiality form in respect of prescribed medication will be signed by every new prisoner and witnessed by a member of staff and another prisoner.

9. Being a recipient of prescribed medication does not exclude a prisoner from participating in mandatory, voluntary or compliance drug testing.

10. Prisoners wishing to be prescribed medication should first discuss it in their small group, and then ask for feedback from the community as a whole. Similarly, where the GP wishes them to have medication this will also require discussion in group.

11. The prescription of medication, although it may imply mental / emotional distress / disturbance, and which may in other circumstances attract a “sick note”, will not be seen as a reason for non-attendance at groups. The commitment is to the talking treatment of therapeutic communities and prescribed medication is seen as an aid to this end, not an answer in itself.

12. A statistical representational chart of medication used within the community will be produced every four weeks.

Anticipated Prescription Drugs

1. Analgesia – wherever possible this should be for non-opiate-based medication. This includes the “co” drugs – co-codamol – co-proximal etc. Prescription of opiate based analgesia should be short term only and for a well-defined condition of moderate to severe pain unless the condition is terminal.

2. Night Sedation. Some applicants may have been prescribed high doses of night sedation for many years. A reducing regime on admission should take no longer than three weeks. There after three days of a herbal product, such as herbal nytol will be all that should be prescribed. This should not be prescribed on more than one occasion per month.

3. Anxiolytics, (drugs used to treat anxiety and panic). Where possible these should be restricted to the beta blockers such as propranolol. Occasionally buspirone may be used for short term management only (maximum two to three weeks). Benzodiazepines will never be prescribed.

4. Antidepressants – these drugs should be reduced gradually during the first six months of admission.
   Applicants taking lithium which has been used to treat bipolar disorder or antidepressants of the mono-amine oxidase inhibitor group are not suitable for treatment in a TC.
   Preferred prescribed is for one of the newer anti-depressants such as an SSRI.

5. Other mood stabilisers – some types of personality disorder manage to achieve stability through using carbamazepine or flupenthixol to stabilise their mood and to manage explosive outbursts. These also should be reduced gradually over the first six months.

Any or all of these may be reinstated where appropriate throughout therapy where clinically indicated and under the guidelines outlined above. Prescriptions should not be for short bursts (other than nytol), should not be of a "on or off nature" and should only be instated following full discussion with the TC as a whole.

Medication Policy Appendix 1

Drugs in Common Use (These may vary between establishments)

Night Sedation: • Mogadon • Zimovane • Welldorm	**Anxiolytics:** • Buspar • Librium • Valium • Inderal • Trasicor • Ativan
Antidepressants: • Cipramil • Prozac • Seroxat • Amitriptyline • Prothiaden	**Mood Stabilisers:** • Carbamazepine / Tegretol • Lithium / Priadel • Largactil / Chlorpromazine

Cautionary Note

Applicants who have been prescribed high doses of drugs commonly used for control of psychotic conditions should not be considered without a full psychiatric screening. Such drugs include

- Largactil
- Haloperidol / Haldol
- Risperdal
- Serenace
- Orap
- Olanzapine
- Sulpiride
- Stelazine

Some drugs are given by **depot injection**, such as

- Modecate
- Depixol
- Risperdal