ARTICLE

Prescribing for people in custody

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SUMMARY

People who are, or have been, in custody often have multiple morbidities and multi-dimensional disadvantage.

A thorough clinical evaluation and multidisciplinary approach will assist in managing these patients. Treatment plans should be pragmatic and simple, and explained in an understandable manner.

Caution should be used in the prescription of any medicines that have the potential for abuse. There is also a risk of drug diversion.

There is an increase in mortality after prisoners are released into the community. Preparations should therefore be made before release to ensure continuity of care.

Introduction

In Australia at any one time there are about 30 000 people in custody (i.e. in police cells, on remand or in sentenced correctional facilities),[1] which is 170 adult prisoners per 100 000 people. During 2013 imprisonment rates for males were 318 per 100 000 men, and for females 26 per 100 000 women. These people may require medical treatment while in custody and this may need to continue when they return to the community.

Patient characteristics

Imprisonment provides a window of opportunity to identify the health needs of a vulnerable and disadvantaged group of people with a high level of morbidity. Statistics vary considerably between states, but there are a number of distinct features of the prison population in Australia.[2] There is an over-representation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people in custody (see Table).

Prisoners have a high prevalence of mental illness, chronic disease, substance abuse and blood-borne virus infections. In an Australian study, approximately 50% reported having been told they had a mental illness and 25% were referred for mental health assessment on admission into custody. About 32% reported having a chronic disease and approximately 22% had tested positive for hepatitis C.[2]

In addition to the burden of illness, there are a number of factors and barriers that influence the delivery of care to people in custody. These include poor literacy, intellectual disability, a history of limited access to health services, challenging behaviours and poor decision making.

Systems are in place to screen patients for chronic diseases, mental health problems, substance abuse and infectious diseases such as blood-borne viruses. Patients identified with these problems are then channelled into programs that manage their specific concerns.

Table **Approximate percentage of people in custody with indicators of social disadvantage and risk behaviours in Australia** [2]

	Indicator	Approximate percentage of people in custody
Social disadvantage	Aboriginal and Torres Strait Islander	33%
	Culturally and linguistically diverse	20%
	Unemployed before incarceration	50%
	Homeless before incarceration	33%
Risk behaviour	Smokes	80%
	Drinks alcohol to excess	50%
	Uses illicit drugs	75%

Prison environment

The prison environment impacts on the delivery of health care, as security requirements coexist alongside the medical requirements of the prisoners. This often provides additional challenges to the provision of health care. Health in prisons and forensic facilities is managed by state government agencies or private corporations. There is no access to the Pharmaceutical Benefits Scheme so medicines are purchased through contract arrangements. On admission, medicines may be changed to

alternatives that are available on the approved formulary. This may mean minor adjustments in medication, for example discontinuation of combination antihypertensive products in favour of individual drugs. Medicines are usually provided to patients daily and administration may be supervised depending on the potential for drug diversion. This may result in adjustments to the timing and dosing of some drugs, for example insulin.

General approaches to prescribing

There are a number of approaches to the management and prescription of medicines to prisoners. As always, prescribing should occur after proper assessment, even in this challenging environment. Use appropriate language and information when providing advice on treatments or disease states. The information provided must be easy to understand, culturally appropriate and may require the use of Aboriginal health workers or an interpreting service. Tailoring and simplifying the regimen to meet patients' needs is also a practical consideration in prison.

Addiction and abuse

Approximately 75% of people in custody have used illicit substances before incarceration.[2] There is concern about the potential of prescription medicines to be used as 'currency', either voluntarily or under duress.

Working in a multidisciplinary team ensures the best care and involves obtaining advice from, or working with, a variety of professionals. This may include pharmacists, nurses, psychologists, physiotherapists, Aboriginal health workers, interpreters, occupational therapists, addiction medicine specialists, psychiatrists, pain management specialists, physicians and surgeons. This particularly applies to chronic disease states, chronic pain and palliative care. The team may need to include representatives from the custodial service as well as representatives from a local hospital.

In general, a practitioner should approach prescribing in custody with the following in mind:

- The basis for a safe and effective treatment is thorough assessment which includes seeking information from GPs, hospitals and other health professionals who have treated the patient.
- The prescription of psychoactive medicines needs to be based on a formal diagnosis.
- It is vital to communicate with others providing care because of the risk of prisoners playing individual clinicians off against one another.
- Always be cognisant of potential drug-seeking behaviours. These include requests for specific drugs, aggressive and unreasonable behaviours, and giving information that is not consistent with objective findings.
- All patients with complex needs should have formal management plans in place.

Cautions

Some prescription drugs, such as benzodiazepines, opioids and GABA analogues, are likely to be misused or diverted. Many others are abused for real or perceived effects. Some reported examples are:

- drugs with anticholinergic effects, like hyoscine, are abused for a 'high' that occurs when smoked
- nicotine patches are boiled up in water to release the nicotine, and the water is then consumed to get an immediate stimulant effect
- mirtazapine and quetiapine are used for their sedative effects.

Benzodiazepines

In all medical practices, including prison, there is the potential for abuse and diversion of benzodiazepines. All prisoners should be supervised when given a dose. Many people enter custody stating they require benzodiazepines, which they say are for epilepsy, but are actually substances of dependence. Benzodiazepines have a place in the management of acute epileptic seizures, however they are rarely indicated for long-term management. If a prisoner is received into custody and is taking a benzodiazepine, in particular clonazepam, for epilepsy, a referral to a neurologist should be made to ensure the treatment is appropriate. In regard to specific drugs:

- diazepam is useful in the management of withdrawal from alcohol, opioids or other shorter acting benzodiazepines
- temazepam is useful for people in some rare acute situations, for example when people are first arrested or in the treatment of insomnia associated with interferon treatment.

Alprazolam should only be used in exceptional circumstances and never in the long term.

Opioids

Prescribing opioids presents a particular challenge in custody. Prisoners known to be dependent should be assessed for placement in an opioid substitution program where available. People who are withdrawing should be managed using established protocols under the supervision of a practitioner experienced in the management of opioid withdrawal.

Many prisoners are taking oral opioids that have been prescribed inappropriately for chronic pain. Opioids work well in acute pain, but their role in chronic non-malignant pain is limited,[3] so a high degree of scepticism should be used when prisoners say they are using opioids for chronic pain. In the first instance a thorough history and examination must be undertaken, including gathering information from other practitioners and looking for drug-seeking behaviours. It is particularly useful to develop skills in examination of the back. Investigations can be difficult to organise in custody and are often less helpful than expected. A multidisciplinary team approach is important. A small number of patients may require opioids for chronic pain, but this treatment needs to be supervised and regularly reviewed.

The National Drug and Alcohol Research Centre has produced useful resources for GPs on opioid prescribing.[4] Currently a real-time system, the Electronic Recording and Reporting of Controlled Drugs, is being trialled in some states. When developed this will assist prescribers in managing patients seeking drugs of addiction in the community and in custody.

GABA analogues

GABA analogues such as pregabalin and gabapentin were originally developed for epilepsy. They have a role in the management of chronic neuropathic pain,[3] however the benefits are limited. These drugs are very frequently abused and have a high currency value in prison.[5]

Psychiatric prescribing in custody

Many people in custody have mental health problems and unfortunately many people who have mental illness only receive treatment when they are imprisoned. People should receive comprehensive team management for their mental health problems. Local protocols that follow accepted standards are used to promote consistent practice throughout the custodial health service. These should be followed for starting and maintaining antipsychotics. The protocols prompt checking for cardiac adverse effects, prolactin elevation and metabolic adverse effects.

Amphetamine stimulants such as dexamphetamine and methylphenidate should be prescribed for indications such as attention deficit hyperactivity disorder only by an approved specialist prescriber.

Many people in custody are prescribed antidepressants. Tricyclics should rarely be started because of their adverse effects and toxicity in overdose. Some patients may apply pressure for antidepressants to be used for sedative purposes, but this should be avoided.

Preparation for release from custody

It is important that patients are prepared for release as there is a higher mortality after release.[6] Patients should be medically discharged with a discharge summary. This can be challenging as release dates may not be predictable. Many prisoners released into the community have complex medical histories, so medical practitioners who see them without a discharge summary should contact the medical records section of the local correctional health service for a copy of the relevant information.

All discharged prisoners should be linked to a GP for follow-up. This can be difficult as many people in prison do not have a GP, do not want the GP to know they were in prison, or will live in a different location on release. Indigenous people can be referred to an Aboriginal medical service.

People with a known addiction to opioids have better outcomes in the community if they are treated in an opioid substitution program. When discharged they need to be connected to a relevant community service.

Patients with mental illness should be stabilised and referred to a community mental health service for follow-up. As they may be released on high doses due to their psychiatric morbidity they require careful monitoring.

Specific arrangements must be made for people undergoing treatment for blood-borne viruses or receiving opioid substitution therapy, to ensure continuity of care following release into the community.

Conclusion

Medical practitioners will treat people who are, or who have been, in prison. It is helpful to realise that these people tend to be from disadvantaged groups, are likely to have significant and multiple morbidity, are less likely to seek help and may have a limited ability to adequately care for themselves. Thoroughly assess these patients and manage their health needs with simple regimens and clear, contextually appropriate explanations. It is best to avoid drugs that are subject to abuse or diversion, and to seek collaboration from colleagues in other disciplines. Managing these patients will not only improve their lives, but also reduce the burden of disease in the population. <

Conflict of interest: none declared

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