

## **Top tips for Healthcare staff starting out in prisons**

**Remember....**

**'The only punishment handed down by the courts is the deprivation of liberty'**

**'The prison service keeps those sentenced to prison in custody, helping them lead law-abiding and useful lives'**

It is rewarding and demanding work, providing healthcare in a prison setting. Primary care, substance misuse and mental health teams, along with other health professionals, have the opportunity to work together to provide integrated care for people, many of whom have complex needs. There are opportunities to address causes and consequences of health inequalities through delivering care at least equivalent to that provided in the community. There are also challenges to overcome when security requirements conflict with providing timely access to healthcare.

You will encounter extremes of illness and related suffering when working in prisons. The opportunity to work with our most vulnerable citizens makes the work particularly rewarding for many clinicians.

It is important to be aware that when someone comes into prison, they have to follow a rigid regime which often involves being locked in their room for several hours each day. They are usually required to share a room with someone they have never met before and often have to use the toilet in front of them, screened by a curtain. Many of our prisons were built over a century ago. The heating, plumbing and lighting may fail from time to time. In addition to this loss of freedom and control, a person may be anxious about a number of issues including family, housing, finances and their court case. They may have a background of abuse or neglect and dysfunctional relationships often with people in authority. This complex mix of factors may lead to problems coping and challenging behaviour which requires patience, compassion and skill to manage.

### **Take advice from multidisciplinary colleagues**

Do take advice from colleagues across the breadth of the healthcare team. Most will have a wealth of experience in the prison setting and can steer you through challenging situations and help you to avoid falling into some 'early days' traps. There are many skills to be acquired and complexities to navigate in communication, risk management, prescribing and collaborative working with clinical and non-clinical prison colleagues. Always be teachable but don't collude with cynicism, prejudice or discrimination. 'Jail craft' is a phrase which describes how people cope with and survive in prison.

Prisons facilitate unique opportunities for specialist staff and primary care teams to work side by side to provide multidisciplinary support and case management for patients, especially where people have complex comorbidities. It is far easier to manage complex problems and make difficult decisions as a team so, if in doubt, don't make an 'on the spot' decision when with a patient but agree to consult with colleagues and to let the patient know the outcome of your discussion. Some prisoners find it very difficult to hear a direct answer of 'no'.

## Managing potential medical emergencies

PSI 03/2013, Medical Emergency Response Codes, provides a framework for managing potential medical emergencies. Officers may request the emergency nurse to attend a 'Code Blue' (or Code One) or 'Code Red' (or Code Two). See Appendix A of PSI 03/2013 (below) for specific clinical presentations and their codes, however simply described, blue means not breathing and red means bleeding.

### Appendix A (PSI 03/2013)

	Prisoner's Symptoms	Mandatory Contingency Responses
<b>Code Blue (or Code One)</b>	<ul style="list-style-type: none"> <li>• Chest Pain</li> <li>• Difficulty in Breathing</li> <li>• Unconscious</li> <li>• Choking</li> <li>• Fitting or concussed</li> <li>• Severe allergic reaction</li> <li>• Suspected stroke</li> </ul>	<ul style="list-style-type: none"> <li>• Communication/Control Room automatically calls an ambulance and awaits updates from the scene</li> <li>• Where available, Duty Nurse attends with necessary equipment and assesses the patient</li> <li>• Where no nurse cover is available, other staff attend with necessary equipment</li> <li>• Gate prepare to receive ambulance</li> <li>• Ambulance escort staff arranged</li> <li>• Escort staff and equipment arranged</li> <li>• Any further action required by the local healthcare commissioner to assist in the preservation of life</li> </ul>
<b>Code Red (or Code Two)</b>	<ul style="list-style-type: none"> <li>• Severe loss of Blood</li> <li>• Severe burns or scalds</li> <li>• Suspected fracture</li> </ul>	

When faced with a potential medical emergency, baseline observations should be undertaken by the assessing nurse prior to the GP/ANP assessment of the patient. An Early Warning Score assessment should be completed and if there is uncertainty but the patient is not so acutely unwell as to require emergency referral, consider monitoring the Early Warning Score over a documented time interval e.g. hourly observations for the next six hours. This will require collaborative effort, particularly if the prison is in patrol or night state and an officer is required to open the patient's door to facilitate observations or the EWS deteriorates and an emergency escort to hospital is required.

### Make clear appropriately detailed notes on SystemOne

Make clear appropriately detailed notes on SystemOne for every patient encounter, whether face to face, providing advice to other colleagues in the healthcare team or prescribing. It is

very likely that, at some point in your career in prison healthcare, you will be asked to attend a Coroner's Court since all deaths in custody are subject to external scrutiny, whatever the circumstances of death as the deceased was under the care of the state. You may also be required to write a witness statement for legal challenges made to the care given by the healthcare team. This may be several years or more since you saw the patient and therefore, your notes are likely to be the only source from which to respond and will be your evidence.

In addition to clear documentation on SystemOne, it is important to share appropriate information with prison colleagues in order to manage risk. This information may be used to inform the ACCT process of self-harm and suicide prevention or to share intelligence that is relevant to the safety of the patient or to others around them in the prison. There will be an observation book on each wing in which prison staff record pertinent entries and in addition information is recorded on the NOMIS system.

**If you are a prescriber, check if there is a prison formulary, treat in line with local and national policies and remember you are part of a multi-disciplinary team**

When you start out working in a secure environment, you may be singled out by prison residents as being a potential 'soft target' for prescribing drugs that may be diverted, traded or abused. As well as more obvious dependence forming medicines, you may be asked to prescribe drugs that would not normally be associated with misuse in the community e.g. T-gel, E45, Aveeno, inhalers, deep heat, pseudoephedrine, loperamide, Gaviscon, ranitidine, cimetidine, cyclizine, mebeverine, hyoscine butylbromide (Buscopan), lactulose, Rectogesic, Anusol, insulin, orlistat, food supplements, TENS machines, paraffin-based products.

T-gel can interfere with UDS and may be used to produce homemade spice. E45 and other emollients may be sold on and 500ml containers may be used to transport drugs or mobile phones (if there is a pump dispenser, the positive signal in a search may be thought to be from the metal spring rather than a secreted phone.) Aveeno and lactulose may be used to make hooch. Inhalers can be used to make bongos or crack pipes. 'Deep heat' may be used to disguise the scent of illicit drugs from sniffer dogs or be used as a weapon when sprayed. Loperamide, cyclizine, cimetidine and Gaviscon may all potentiate opiates. Buscopan, ranitidine, loperamide and pseudoephedrine can produce psychoactive effects. They are often snorted. Rectogesic may be used to enhance sexual performance and Anusol may be used as an anal lubricant. Food supplements, insulin and orlistat may all be traded and abused by body builders. TENS machines can be used to power mobile phones or make into tattoo guns and any paraffin-based products may be used as arson supplies.

It is important to be aware that a number of prescribed and OTC medicines may alter UDS results. It may therefore be helpful for further detailed hospital urine drug screen tests to be carried out on a sample if a person has no history of substance misuse but has a positive UDS since this may have a significant negative impact on their progress through their sentence. The following list is not exhaustive: T-gel, ranitidine, mebeverine, bupropion, diphenhydramine, ibuprofen, naproxen, promethazine, quetiapine, sertraline, trazodone, venlafaxine, diltiazem, verapamil may all alter urine dip tests for drugs.

DO use the prison formulary and DO NOT agree to start or increase the dose of any medication that has the potential for abuse without first discussing with colleagues. If you are unsure of why a patient may be asking for a particular medicine and there is no immediate obvious clinical need, decline to make an 'on the spot' decision, consult with colleagues and let the patient know the outcome of your discussion. This is very important for medicines of abuse and dependence but it is also wise to consider this advice for apparently harmless requests. For example, you may be asked to prescribe 'E45' for dry skin. If there is an agreement in your prison that emollients must be purchased from the canteen or should only be prescribed from the formulary for diagnosed skin conditions and you agree to prescribe E45 for dry skin, this will cause significant difficulties for other colleagues and for yourself when word spreads and a vast number of requests for E45 are made by other residents.

If you are a visiting prescriber e.g. specialist, any medicines that you choose to initiate should be prescribed directly onto SystmOne, at the time of the consultation or shortly afterwards and not be left to another prescriber. There should be instructions about any repeat prescriptions that will be required prior to your next review.

### **Keep professional boundaries with patients and manage difficult behaviour consistently**

Many residents in prison have been let down repeatedly by those they should be able to trust in their lives. Make sure that if you say you will do something (e.g. ask a colleague, make an appointment, add someone to a waiting list, get back them) DO IT! Don't offer what you or others cannot deliver. If you are unable to do something politely explain why and discuss what other options are available (the skilful way of saying NO).

Many residents in prisons, have complex personalities or personality disorders, often shaped by adverse childhood experiences. Do not be falsely flattered by comments such as 'You're the only one who understands', 'You're the best doctor/nurse' or 'You're the only good doctor/nurse here'. While your role is to ensure that you communicate well and provide high quality care, remember there may often be a very good reason that someone else in the team has declined a patient's request. Understand what collusion, grooming and boundaries mean.

Do not be forced into making precipitous decisions about patient care that you do not feel comfortable with. Always remain compassionate and aware of people's past traumatic experiences, but also be prepared to become the 'worst doctor/nurse ever' if this will be the result of making a safe, clinically appropriate decision. To have a 'smooth ride' or a less stressful consultation in the short term may set others or yourself up for a difficult time in the long run and end up dividing the team. If a patient threatens to 'sue you' or 'cut up' or 'kill' themselves or you if you do/don't do something, it is reasonable to consider ending your conversation with them and agree to see them again when they are calmer. It is important not to reward dysfunctional behaviour as this is very likely to cause it to escalate later on. You may need the assistance of a prison officer to remove the patient at that time to support them while they become calmer.

If a patient becomes threatening, abusive or aggressive, stay calm and ask the officer to remove them immediately. Advise them that their behaviour will be reported and ask the

security staff for help in completing an incident report. Make a Datix entry or ask a colleague to help you do this to ensure that the abuse is highlighted through the appropriate channels. If you do not follow up on unacceptable behaviour, this will be confusing for the resident and will not help in their rehabilitation. They may not have lived with clear boundaries and consequences to their behaviour while growing up and, while distressing in the short term, consistent and clear discipline will be helpful in the long run.

### **Liaison and diversion, Learning disabilities and Vulnerable Adults**

As a result of their behaviour, people may come into contact with the criminal justice system who have learning difficulties, learning disabilities or mental health problems. Liaison and diversion teams are set up to identify people with vulnerabilities when they come into contact with the police or courts and assess their needs, offer advice on their case management, and ensure they are offered treatment and support if needed.

Liaison and Diversion service teams will identify those who lack capacity and who are unfit to be held in custody however learning disabilities and difficulties (LDD) and mental health problems are common in prison (LDD c.1/3 prison population; 26% women, 16% men treated for mental health in year prior to custody). Those with LDD are more likely to struggle with the prison regime and may be abused or bullied by other residents. It is important to be aware of their potential vulnerability particularly if you are asked to assess someone who has been displaying challenging behaviour or who is being held in segregation conditions. They may require additional support to understand the prison regime, to be protected from bullying or to manage their emotions and mental health. It is important to be aware that people on remand are at greater risk of self-inflicted death and that 70% of those who die will have had mental health needs identified.

### **Dirty Protests**

Dirty protests began during The Troubles in the late 1970s and early 1980s, in the Maze Prison and Armagh Women's prison in Northern Ireland, as part of a 5 year protest by the IRA and INLA over loss of Special Category Status. 'Dirty protest' behaviour is usually with the intent of demonstrating non-compliance with the prison regime. It may involve defaecating or urinating in a room without using toilet facilities provided, smearing faeces over walls, ceiling, floors and possibly over the body. It may also involve blood or other body fluids. The main concern with this behaviour for the healthcare team is health protection.

While a person is on a dirty protest, healthcare staff may be requested to assess them if there are concerns about their health. If this is the case, PPE should be worn, including disposable overalls impermeable to fluids, plastic overshoes, activated charcoal face mask, disposable gloves and eye protection (eye shield or goggles). Staff should be offered the opportunity to shower after entering a room in which a dirty protest is taking place.

Further guidance on health protection issues can be found in: Department of Health/Health Protection Agency publication (2011) *Prevention of infection and communicable disease control in prisons and places of detention. A manual for healthcare workers*  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file)

## **Escorts and bedwatches**

Remember you are working within a prison which has a regime to run and security requirements to be upheld. You also have a duty of care to each patient. Sometimes healthcare and security priorities come into conflict. If you are unsure what to do if challenged by a member of the security team about a decision you have made relating to someone's health e.g. the need for immediate transfer to hospital, ask a senior healthcare colleague for advice and clearly document the decision making process on SystemOne. If you are certain that transfer out of the prison is imperative ask to discuss this with the duty governor.

There will be an agreed allocation of escorts for healthcare each day to facilitate planned hospital appointments, investigations and treatment. If an emergency arises, e.g. an assault resulting in trauma to a resident that requires immediate assessment and treatment in hospital, you may be asked to decide which of the planned hospital escorts should be cancelled to facilitate the emergency. It is important to prioritise clinically and this is best done in discussion with a senior member of the healthcare team due to the potential impact on the patient whose appointment is being deferred.

It is very important not to breach the security requirements of the establishment. These will vary according to the category of the prison you are working in however, as a basic rule, DO NOT let a patient know the details of any appointments outside the prison as this poses a security risk. In addition, if a patient becomes aware of the details of their appointment or knows about it because it was arranged prior to coming into prison, it is likely that the appointment will need to be rearranged. Most absconding occurs during planned hospital appointments.

The security risk of every escort outside the prison is individually assessed and will depend upon the person and the movement type. The risk assessment takes into account the medical condition, the security category of the person, the nature of the offence, the risk to the public and hospital staff, available intelligence, the risk of escape and restraints to be used in transit and when at the hospital.

You may be asked to provide an opinion about use of restraints, particularly if a person's condition is to deteriorate in transit or while at the hospital for outpatients or on a bedwatch. You may also need to advise security staff about the person's mobility (e.g. use of crutches), nature of an injury (e.g. suspected wrist fracture) or an examination or investigation (e.g. colonoscopy) which may make the use of a long chain more appropriate than other restraints. Be aware that there are specific requirements around the use of restraints during pregnancy.

Ultimately, the security risk lies with the prison and details about escorts can be found in PSI 33. There may be rare occasions when your opinion about the need for emergency transfer to hospital is overridden by the prison due to the security risk of an individual. If this occurs, inform senior members of the healthcare team and if they are in agreement with your

opinion, ensure that the prison is made aware they are acting contrary to healthcare opinion and that the responsibility will lie with them if a person's health deteriorates.

### **Handling residents' requests**

You may be asked by residents to write 'an F35'/a letter to support additional mattresses, new chairs, bottom bunk, single cells, specific diets, ground floor location (locate flat). Find out the arrangements that have been agreed between healthcare and the prison where you work. Many healthcare departments have an agreement with the prison that furniture associated with a person's accommodation lies outside the remit of healthcare advice. Bottom/top bunk allocation is usually negotiated between residents who share a room.

Depending on their availability in a prison, single cells are highly sought after by residents. Some residents will have been assessed as 'high risk' by the prison due to the safety risk they pose to others. If a decision is required about single cell location on healthcare grounds, a multi-disciplinary team discussion is usually required. Be aware that you may be asked by a resident to write a letter supporting a single cell even if a decision has already been made and communicated to the them. Check with colleagues and decline to make any decisions on the spot.

Ensure that any dietary recommendations that you make to the prison kitchen are on valid medical grounds, which have been confirmed. If necessary, write to the patient's community GP. It is not the role of the healthcare team to make recommendations about diets due to religious reasons.

### **Continuity of Care**

Timely communication of all relevant medical information, including prescribed medicines, risk of self-harm and suicide, substance misuse, mental and physical health problems and outstanding hospital appointments is extremely important for the safety of a person coming into prison from police custody or court and when they are being transferred to or from another prison or being released back in to the community. It is also important to share necessary medical information and to provide medicines that will be required while someone is out at court or when attending hospital during the day. A Person Escort Record (PER) will accompany every person on every transfer within the criminal justice system. It is important that adequate medical details are completed on the PER by the sending healthcare team and important for the receiving healthcare team to read and be aware of these.

Sometimes, very little information will arrive with a patient and they may have no medicines with them. If they have an NHS number, a patient's summary care record (SCR) may be available either through SystemOne or the internet. Old prison records will also be accessible through S1. It may be possible to contact the community GP or pharmacy where medicines have been dispensed. Further details about prescribing and management of medicines can be found in national guidance by RPS, NICE and RCGP (see references).

## **Medical Hold**

It is important for people in custody to be able to move through the prison system in a timely way in order to access relevant courses and progress through their sentence. The prison OMU department is responsible for oversight of transfers and people may remain in one prison for many months or just a few days. While it is important to move people through the prison estate, it is the job of the healthcare team to ensure that a person's medical needs are also met. If a referral to hospital has been done and an appointment date has been received for assessment or treatment, it is important that a person is able to attend the hospital appointment unless their care can be transferred to another area without resulting in a delay that could compromise their health. This is especially important in two week wait cancer referrals.

Prior to each person's transfer (except in exceptional circumstances such as security moves), the healthcare team is likely to be asked to confirm whether or not someone is fit to move from the prison. Details of medical hold agreements will be individual to each prison and healthcare team so, when starting out, it is important to check with experienced staff before making a decision about an individual's suitability for transfer, particularly if you are planning to overturn their medical hold status. If a person is transferred to another prison with outstanding investigations and treatment from specialist services, it is important for a formal handover to be given to the receiving prison to highlight these.

## **It can feel overwhelming at times**

People come to prison with a variety of physical and mental health problems and substance misuse issues. Many have lived with abuse and deprivation and may have neglected their health due to more pressing priorities such as food, shelter, drug acquisition or sometimes in order to evade the police. Whilst work in community healthcare has many attendant stresses, the complexity of caring for people in prison whose needs and behaviour may be particularly challenging can be draining, particularly if there is a significant event such as a death, or if a patient makes threats either to take legal action, to report staff to governing bodies such as NMC and GMC or threatens or carries out acts of physical violence.

Peer support and supervision together with effective collaborative multi-disciplinary team work are extremely important in remaining a compassionate effective healthy healthcare professional. It is tough but it is definitely worth working with people who are in the criminal justice system. You can make an enormous difference to their journey towards recovery and a meaningful contribution to society!

## **ABBREVIATIONS YOU MAY HEAR IN PRISON**

ABH - Actual Bodily Harm

ACR - Automatic Conditional Release

ACCT - Assessment, Care in Custody and Teamwork

Adjudication - a mini court hearing which takes place inside the prison if a resident is alleged to have broken a prison rule



Association - A period of time in which prisoners mix together under supervision for recreation

Basic – status of resident when loss of an earned privilege or demotion to a lower level. Usually seen as a consequence of deterioration in behaviour or refusal to engage in interventions designed to reduce the risk of re-offending

Buddies - Selected and trained prisoners who help other prisoners

C&R - Control and Restraint

CAT (Category) - Refers to the security classification of an inmate

Functional Head - Person in charge of an area i.e. Residence Head

Cell – prisoner’s room

Closed Visit - **visit** where the prison resident and their visitor are prevented from having any form of physical contact and from passing any items to each other.

CM – custodial manager (3 stripes) – most senior grade of uniformed officer

Code Blue – emergency response code often used to indicate if a prison resident has breathing difficulties (they may have been found hanging or having a seizure)

Code Red – emergency response code often used to indicate that a prison resident is bleeding – this may be due to self-harm or to assault.

Detox – assisted withdrawal from a substance of misuse (drug or alcohol) using a progressively lower dose of prescribed medicine

DIC – Death in Custody

Distraction Pack – pack of activities e.g. colouring, crosswords to distract residents who are having distressing thoughts and reduce the risk of harming themselves.

DSH – deliberate self-harm

Enhanced – status of resident that earns them longer or more visits and other privileges

Entry level – status of resident when they first start in prison

Standard – status of resident who has not incurred losses or earned enhanced status

GOOD - Good order or Discipline

GBH – grievous bodily harm

HCC - Health Care Centre

HMIP - Her Majesty's Inspector of Prisons

HMP - Her Majesty's Prison

IEP – Incentives and Earned Privileges (a system for rewarding good behaviour)

IR – Mercury Information report

IMB - Independent Monitoring Services

IP – in possession (medicines can be kept by the patient; DIP daily in possession, WIP weekly in possession, full IP – 28 days in possession)

Key worker- A named member of uniform staff allocated to a prisoner

KPI - Key Performance Indicators

KPT - Key Performance Target

L&D – Liaison and Diversion – services which aim to identify people who are vulnerable due to mental health, learning disability, substance misuse or other issues when they first come into contact with the criminal justice system as suspects, defendants or offenders in order to improve health and justice outcomes

Lifer - Life Sentence Prisoners

Line - Piece of material or string used to deliver or collect something to or from another cell

Listener - Prisoner Samaritan

Lockdown – a security precaution where no movement of prison residents is allowed and no one may enter or leave the establishment

Locked up with – sharing a cell

Losses – loss of earned privileges, usually a consequence of poor behaviour or refusal to engage in interventions designed to assist rehabilitation

LSS - Local Security Strategy

Medical Hold – where a resident is unfit to transfer due to medical problems (usually for urgent or imminent hospital appointments or treatment.)

MDT - Mandatory Drug Testing

Netting – the metal meshwork between levels of a wing. You may hear that someone is ‘on the netting’. This is usually a protest behaviour.

NFA - No Fixed Abode

Nicking - A disciplinary charge (adjudication) received if a **prison resident** is alleged to have breached a **Prison Rule**.

NIP – not in possession – a patient’s risk is too high to keep medicines in possession

NOMS - National Offender Management Service

On the Rule - Refers to someone segregated under Prison Rule 45

OO - Orderly Officer

OSG - Operational Support Grade (prison staff who have little or no direct contact with resident. They do not have any stripes on their epaulettes)

OMU – Offender Management Unit (OCA – Offender Categorisation and Assessment unit – dept within OMU responsible for identifying suitable prisoners for transfer)

Pad - Prisoners room

Pad mate – room mate

Patrol State and night state – the prison is locked with no movement of prisoners. Special permission, usually from the orderly officer, is required to open up any cells.

Pegging - An arrangement which allows managers to determine whether or not the Night Patrol (OSG) has patrolled during the night

PEI - Physical Education Instructor

PER - Person Escorting Record. Documentation confirming that a prisoner has been handed over e.g. from Prison Service to Group 4 for court appearance etc.

Plugging – when someone has items (e.g. illicit drugs or phones) stored in their person (usually in the rectum)

POA - Prison Officers Association

PSI - Prison Service Instruction

PSO - Prison Service Order

Remand – Status of a prisoner who has been accused of an offence and obliged to remain in prison until their case has been heard

RoTL – Release on Temporary Licence

Runners – officers escorting patients to and from healthcare clinics

SLA - Service Level Agreement (an agreement held between a healthcare provider and another subcontracted health provider which defines the level of service that will be provided, targets to be met and penalties if they are not)

SO – Supervising Officer (2 stripes) – in charge of day-to-day running of a wing, responsible for all of the staff and **prisoners** there.

SIM meeting -

SIR - Security Information Report

SORTT – Supporting Offenders Recovery Treatment Team. This team consists of NHFT clinical staff and the WDP team who provide psychosocial therapies  
SMT - Senior Management Team  
SPDR - Staff Performance and Development Record  
SSU ('The Seg') – Separation and Support Unit or Special Supervision Unit; in some prisons called CSU – Care and Support Unit or Segregation Unit  
Stand Fast Roll Check - Prisoners have to be accounted for. No prisoner movement during this time  
STT – see to take (medicine to be taken under supervision)  
The Rule – Rule 45 – someone signed up to R45 is located in a segregated area  
Toil - Time off in lieu  
Trainer – a training prison where  
Transfer – The movement of a prison resident from one establishment to another ('Going on transfer')  
VO - Visiting Order  
VP – vulnerable prisoner (someone who has signed up to Rule 45 so that they are housed separately for their personal safety)  
Wing - Parts of the prison containing cell accommodation  
YA – young adult (18-20)  
YOI - Young Offenders Institution (secure setting for people aged 18-20y)

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