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Pharmacists: taking charge of minor ailments and unlocking prison health

In this article **Rod Tucker** discusses the potentially valuable role that pharmacists can play in managing the health of patients held in custody

It has been estimated that minor ailments account for as much as a third of GP consultations. This is equivalent to 300,000 consultations every day.[1] Moreover, research suggests that minor ailments and injuries account for between 30 and 40 per cent of attendances at accident and emergency departments.[2] Transferring minor ailments in the community from GPs to pharmacists has been shown to reduce GP workload for those ailments[3] and such schemes have been shown to be well received by patients who use them.[4]

Indeed, the success of minor ailments schemes has led to the Government pledging support for such schemes in the report "Building the best — choice, responsiveness and equity in the NHS"[5] and the development of the role of pharmacists has more recently been recognised in a report "Choosing health through pharmacy"[6] and in the community pharmacy contract which includes minor ailments schemes as an enhanced service. Furthermore, a comprehensive review of the literature has shown that patients expressed a high level of satisfaction with the level of services provided by community pharmacists.[7]

The Home Office was responsible for the health care of prisoners until April 2006 when that responsibility was transferred to the NHS and, in particular, primary care trusts. The stated aim of prison health care has always been one of equivalence, that is, prisoners are to have the same access to services provided to patients in the NHS.[8] This represents a potentially huge challenge given that prisoners exhibit a high rate of mental illness and are more likely to abuse drugs and alcohol than patients in the general population.[9] Furthermore, a recent study has shown that numerous factors, including distrust of "the system", provide a barrier to prisoners seeking medical help for such mental distress which only serves to compound the problem.[10]

Health care for prisoners has been traditionally provided by doctors (medical officers) and nurses. Pharmacy services in prisons were the subject of a joint prison service and Department of Health report in 2003,[11] although there appears to be little information available on the role of pharmacists in managing patients in prisons. There is, however, some evidence that prisoners with skin problems value services provided by a pharmacist.[12]

In the report on pharmacy services for prisoners, it is recommended that pharmacists provide services for prisoners with minor ailments as done in the wider NHS. This allows medical staff to concentrate on more serious problems, which is an onerous task, given that evidence suggests that prisoners in the UK are likely to consult doctors three times more often than a demographically equivalent community population.[13]

There appears to be little information published on the health care of prisoners. A literature review of prison health care found that the main issues are mental health, substance abuse and communicable disease. It also identified women and older prisoners as groups whose health care needs are different from those of the wider prison population.[14] A second review on the primary care nursing of prisoners extended the list of prisoners with additional health care needs to include those from ethnic minorities and younger prisoners.[15] However, the reviews did not uncover any specific information about the role of pharmacists in the management of patients with minor ailments, even though this role is well established in the community.

The remainder of this article describes the range of conditions that I have seen and activities I have undertaken over a period of 33 months while working at Her Majesty's Prison Hull, a local category B prison that holds approximately 1,000 prisoners and contains a mix of remand and sentenced prisoners.

Development of the clinics

Waiting times for access to medical staff were as long as three weeks. In addition, as many as 20 patients were booked into each medical clinic every day between Monday and Friday. Time restrictions imposed (prisoners had to be back at the wings by a certain time every day) meant that it was not possible to deal adequately with the health needs of them all.

When prisoners applied to see someone in the health care department, the applications were sorted and then allocated to either the medical officer or to me. I had worked in a prison before, was used to consulting and was experienced in dealing with skin diseases.

It was initially decided that patients who required simple analgesics or topical therapies for skin diseases and other minor ailments, amenable to treatment with over-the-counter medicines, could see me first and, if required, patients would then be referred to the medical staff. Over time, the range of conditions seen increased as I became more experienced and was able to treat a greater range of conditions. In addition, patients who wanted advice or further information about their treatment were also seen by me and I would conduct, where appropriate, clinical medication reviews. I also trained as a supplementary prescriber and, through the use of clinical management plans, was able to prescribe for a range of conditions, although this was restricted to skin diseases since I had more experience of treating patients with these conditions. I worked full time at the prison and clinics were held every day. There were, on average, 12 booked appointments per clinic and clinics were held in the morning and afternoon.

Conditions encountered at the clinics

From July 2004 to April 2007, data were collected on all prisoners who were seen at the pharmacist clinics and details of the consultations were recorded on a database. A total of 1,348 contacts were made with 986 individuals. The conditions seen at the clinics were divided into skin problems and minor ailments. In total there were 498 contacts for skin problems and 850 contacts for what were defined as minor ailments. The range of skin problems encountered and the different minor ailments seen are shown in Tables 1 and 2, respectively.

As can be seen in Table 1, the most commonly encountered skin condition was eczema, and included all types of the condition. Table 1 also shows that tinea infections were common. This includes tinea pedis, tinea veriscolor and infections on the hands and toenails. The category for "other" conditions was wide and included scabies, skin infections, viral warts and impetigo, as well as simple advice and reassurance for patients when no treatments were issued.

Table 2 shows the range of minor ailments encountered and medicines-related activities undertaken. The most common ailments were toothache, insomnia, backache and headache, including both tension-like headache and migraine. The term "analgesia" refers to prisoners who presented with various aches and pains, usually musculoskeletal, for which simple analgesics were sufficient.

Table 1: Range of skin conditions seen (n=498)

Condition	Percentage of patients with condition
Eczema	29
Tinea infections	19
Other	17
Acne	14
Psoriasis	11
Dry skin	7
Urticaria	3

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Table 2: Minor ailments seen and activities undertaken (n=850)

Minor ailment or activity	Percentage of patients with condition
Toothache	12
Medication review	12
Other	11
Analgesia	10
Backache	9
Headache	9
Insomnia	9
Advice	9
Administration	7
Gastro-oesophageal reflux disease/dyspepsia	5
Drug misuse	4
Constipation	3

Prisoners often experienced backache due to the nature of the mattresses which are said to be uncomfortable and, in some cases, exacerbated an existing back problem. Moreover, although insomnia was a presenting problem in itself, many prisoners reported an inability to sleep due to backache.

Medication reviews included both a clinical review of prisoners' prescribed medication, sometimes with a view to undertaking product switches, as well as a treatment review of medicines previously prescribed by me. The "administration" category refers to consultations in which prisoners were seen for risk assessments for "in possession" medicines as well as for completion of sick notes and other administrative functions. For example, prisoners were required to seek health care professional approval before being allowed a new mattress in cases of confirmed back problems or a single cell for various health-related reasons. A range of "other" conditions included osteoarthritis, ear wax, asthma, coughs and colds, hay fever and diarrhoea. The "advice" category again addressed a number of problems, ranging from requests for information about medicines to advice and help related to being in prison, and the frustrations felt by prisoners as they were unable to cope or deal with family or personal problems in the outside world. In many cases, simply listening and talking about a prisoner's problems with them was sufficient to allow them to cope better with their difficulties.

A few prisoners were seen regarding their drug misuse having made a general request on their application for advice or further medicines. In most instances such prisoners were referred to the substance misuse team for further advice and help.

Discussion

Six conditions, namely toothache, insomnia, headache, dyspepsia, constipation and backache, accounted for nearly half (47 per cent) of all minor ailments consultations. With regard to skin conditions seen, only four problems, namely acne, eczema, psoriasis and tinea, accounted for nearly three quarters (73 per cent) of all consultations. It is difficult to compare the results with those from other minor ailments schemes in community pharmacies since the type of patients are different. For instance, one study on transferring care from GPs to community pharmacists found that the main conditions transferred were for treatment of head lice and indigestion.[3] It was also reported that a minor ailments scheme in Sheffield also saw head lice as the major condition treated.[16]

Analysis of conditions seen within prisons is limited. One study, in Geneva, compared all prescriptions from a local prison with an outpatient clinic in the community.[17] This study showed that, in the prison, the most commonly prescribed non-psychotropic drugs were simple analgesics such as non-steroidal anti-inflammatory agents, dermatological treatments, anti-infective agents and drugs for gastrointestinal disorders. However, this study mainly compared treatments prescribed whereas the HMP Hull study did not consider treatments prescribed. Nevertheless, the analgesics prescribed were restricted to those available through pharmacies, such as ibuprofen and paracetamol. Indeed, the study by Elger[17] noted that ibuprofen was the most frequently prescribed NSAID at the prison.

There is some information about the prescribing of dermatological agents in prisons from a study in another UK prison.[18] This article found a similar proportion of prisoners suffering with eczema (30 per cent versus 29 per cent in the HMP Hull study) and tinea (15 per cent versus 19 per cent in the HMP Hull study) and psoriasis (10 per cent versus 11 per cent in the HMP Hull study). However, there was a much higher proportion of prisoners with acne in the previous study and this might well reflect the fact that the previous study was conducted in a prison with a high proportion of young offenders.

In the future it is expected that further work will be done to explore the potential role of pharmacists consulting in similar places. For example, what has not been explored is the proportion of prisoners who do not need to consult the doctor after their appointment with the pharmacist. Anecdotally, it seems that the waiting time to see medical staff has reduced because of the pharmacist clinics but there are currently no hard data to support this. Furthermore, it would be useful to obtain the views of prisoners who are treated by the pharmacist with, perhaps, a patient satisfaction survey. Some work with prisoners presenting with a skin problem has suggested that, overall, prisoners are satisfied with the advice and treatment received from the pharmacist.[12,19] Finally, with the potential for pharmacists to achieve independent prescribing status, it would be useful to explore and contrast the range of conditions and treatments provided by pharmacists and medical staff.

Conclusion

This article has described, for the first time, the range of presenting conditions seen at a pharmacist-led clinic in a prison and has demonstrated the feasibility of conducting such clinics as suggested in the pharmacy services for prisoners report. Although simply an overview of the work involved, this article has demonstrated the potentially valuable role that can be provided by pharmacists in managing patients with minor ailments in prison.

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