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# Clinical Management of Drug Dependence in the Adult Prison Setting

## Including Psychosocial Treatment as a Core Part



National Treatment Agency  
for Substance Misuse



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## Executive summary

This document describes how clinical services for the management of substance misusers in prison should develop during the next two years as increasing resources permit. The aim is to address the current challenges facing the care and treatment of substance misusers in prisons. These include:

- the vulnerability of drug-using prisoners to suicide and self-harm in prison, and to death upon release from custody due to accidental opiate overdose;
- prison regime management problems related to illicit drug use in prisons;
- the impetus to provide clinical services that correspond to national (NTA 2003) and international good practice;
- the need to provide clinical interventions that harmonise with practice in community and other criminal justice settings (NOMS 2005);
- the need to integrate further healthcare and Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services in prisons, to create multi-disciplinary drug teams.

To these ends, this document has been drafted in consultation with key government departments, professional organisations, commissioning organisations and service providers. These include:

- HM Prison Service;
- Department of Health;
- Home Office;
- National Treatment Agency;
- National Addiction Centre;
- National Offender Management Service Drug Strategy Unit;
- Prison Officers' Association;
- Royal College of Psychiatrists;
- Royal College of General Practitioners.

The document also takes account of work being progressed through the Drug Interventions Programme (formerly known as the Criminal Justice Interventions Programme – CJIP).

In recent years, there has been substantial progress in the provision of non-clinical drug services across the prison estate. Clinical services have been slow to develop by comparison. Detoxification, of a pre-set duration, remains the solitary prescribing response to drug dependence in the majority of local prisons.

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While detoxification may remain the preferred method of clinical management for some drug-dependent prisoners, it is now apparent that a range of clinical treatment options are required to manage the varied and complex needs of this patient group.

The principal elements of this model are as follows:

- Prescribed management of withdrawal by a doctor in reception in a local prison, to lower risk of suicide, informed by the reception health screening and assessment.
- Stabilisation on a licensed opiate substitute medication for a minimum of five days prior to progression to one of the following three treatment options:
  1. standard opiate detoxification (minimum duration of 14 days);
  2. extended opiate detoxification (21+ days);
  3. opiate substitute maintenance (up to 13 weeks or beyond, dependent on individual clinical need).
- Safe and effective alcohol detoxification in line with the Prison Alcohol Strategy (2004).
- Effective, evidence-based management of benzodiazepine withdrawal (BNF 2005, DH 1999).
- Clinical monitoring of stimulant withdrawal.
- Good-quality joint working and case management between clinical teams, CARAT services and Criminal Justice Integrated Teams (CJITs).
- Progression, through CARAT case management, to other Tier 3 and 4 services in prisons, such as rehabilitation programmes and therapeutic communities.
- Joint management and care planning by primary healthcare teams, mental health in-reach services and substance misuse teams of individuals with co-existing mental health and substance misuse problems (dual diagnosis), with a view to a harm-minimisation approach (Royal College of Psychiatrists, 2003).
- Ongoing reviews of all extended prescribing regimens, informed by random clinical drug tests.
- Provision of a minimum 28-day open intervention of psychosocial support for all prisoners with problematic drug use.

In a local prison, patients should initially be accommodated on a unit that offers access to unrestricted 24-hour observation, utilising open healthcare hatches where they have been installed. When new-builds or refurbishments are undertaken, these facilities should be created.

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This guidance is intended to serve as a document upon which future developments in clinical services in prisons may be commissioned. It is formulated as a treatment model, to cover a period from reception into custody, up to and beyond 28 days thereafter. It seeks to set out the key components of this type of care, which are reception screening, assessment, clinical management and psychosocial interventions.

All prescribed regimens should be supported by evidence, conform to PSO 3550 (HM Prison Service 2000) and DH (1999) guidelines and adhere with the principles of clinical governance.

The model will be supported by an ongoing training programme to ensure that staff develop the skills and knowledge required for the competent delivery of the approach outlined in this guidance. There should be provision of access to training and support for all clinicians working with substance misusers in prisons.

This guidance is intended for all healthcare professionals working with substance misuse in prisons. It is strongly advocated that, wherever possible, prisons and primary care teams should seek the involvement of a substance misuse specialist doctor in the planning, delivery and support of clinical services.

To inform commissioning and to optimise continuity of care, this guidance should also be made available to primary care trusts, Drug and Alcohol Action Team partnership commissioners, community drug and alcohol treatment providers, Drug Interventions Programme project managers and CJITs.

This document shall be reviewed within a year in the light of any new research within the prison system, the improved training of clinicians working in prisons and the results of the National Institute for Health and Clinical Excellence guidance and technology appraisals of buprenorphine, methadone and naltrexone.

This model applies only to prisoners aged 18 or over. Guidance on the clinical management of substance misuse problems for younger people in secure settings will be published later this year.





## 1 Introduction

- 1.1 There is an increasing awareness within the Prison Service of a correlation between drug withdrawal and self-destructive behaviours. One of the principal recommendations from the Prison Service internal review of prevention of suicide and self-harm in prisons is that:

‘The Prison Service should pay special attention to the safe management of prisoners in the early stages of custody in a prison, with a focus on excellence of care for all prisoners in reception, first night, induction and detoxification units.’

(HM Prison Service 2001a)

- 1.2 A broader range of clinical responses to drug dependence, such as extended opiate detoxification and maintenance programmes, could serve to reduce incidents of suicide and self-harm among those most at risk, including individuals with co-existent drug and mental health problems. Other regime management benefits, such as reduced drug smuggling via reception and fewer incidents of violent aggression, have been noted in prisons where a broader range of clinical services has been developed.
- 1.3 Drug users are at a greatly increased risk of death during the first week of release from prison (40 times greater than the average mortality rate, see Home Office Online Report Series (HOORS) 2003). The predominant cause of these deaths is accidental drug overdose. Loss of tolerance to the toxic effects of opiates following detoxification would appear to be a very common precipitating factor.
- 1.4 The range of clinical responses to drug dependence recommended in the HOORS (2003) study includes methadone maintenance. In its review of drug policy and treatment, the Home Affairs Select Committee (2002) recommended that methadone maintenance should be available across the prison estate. It is acknowledged that there has been considerable unease around this practice within the Prison Service, but through careful evaluation and study, it has become apparent that this intervention within a prison setting can lead to important harm reduction benefits (Dolan 2003).
- 1.5 A more organised and systematic approach to clinical management across the estate is desirable, taking into account the patient’s own view on the management of their substance-misuse problems.
- 1.6 Individual clinicians and establishments as a whole will benefit from the enhanced protection of a systematic approach to the management of drug dependence. This does not of course preclude alternative treatment by an addiction specialist where clinically appropriate. This document describes how clinical services for the management of substance misusers should develop during the next two years as resources permit. This model, which covers a period from reception in to custody, up to and beyond 28 days thereafter,

seeks to set out the key components for such an approach, which are reception screening, assessment, clinical management and psychosocial interventions.

- 1.7 Continuity of care is vital to the treatment and support given to problematic drug-misusing offenders as they move between different criminal justice and treatment agencies. Improvement of continuity of care for the individual is reliant upon seamless case management through the effective provision and communication of the right information at the right time to the right people, throughout the treatment 'journey' of the patient. The Drug Interventions Record (DIR) establishes a common tool for use by CJITs in the community and drug treatment services in prison. The DIR features a minimum set of data for monitoring on one side, with additional free text space for continuity of care information to enable the worker to describe individual circumstances in more detail. The DIR facilitates continuity of care and minimises duplication of assessments, particularly when individuals are moving between custody and community but also when information is passed between case managers and/or treatment providers (with consent).
- 1.8 CARAT teams are the case managers for all drug treatment interventions in prisons and will liaise with prison resettlement workers, probation/offender managers (where appropriate) and CJITs when preparing release plans in order to ensure that drug-related needs are identified pre-release and appropriately addressed post-release. Effective resettlement of any drug misuser requires the development of a holistic package of support. Aftercare is the package of holistic support that needs to be in place when a drug misuser leaves custody. It involves access to additional support with a range of issues that may include housing, managing finance, rebuilding family relationships, learning new skills and employment. Early planning pre-release will enable continuity of care and access to wraparound support to be provided at the time when it is needed.

## 2 Risk management

Much of clinical substance misuse practice is directly concerned with the management of risk. This table summarises methods to manage risks, some of which are particular to clinical substance misuse work in a prison setting.

Risk area	Risk	Recommended management
Self-inflicted deaths and drug and alcohol withdrawal	<p>Heightened risk of suicidal and self-injurious behaviour among opiate-dependent prisoners in the first 24 hours of custody in prison</p> <p>Opiate-dependent prisoners remain at a raised risk of suicide and self-injury throughout the first 28 days and, in particular, during the first 7 days of custody</p>	<p>Provision of prescribing for opiate withdrawal by a doctor in reception of a local prison, on the day/evening of admission</p> <p>Opiate withdrawal to be managed by opioid stabilisation and subsequent planned care (section 5.4)</p> <p>Joint working between clinical teams and residential staff, to include:</p> <ul style="list-style-type: none"> <li>• information-sharing protocols (see the SECURE prisons mental health CD-ROM)</li> <li>• information and training for residential staff on working on a withdrawal management unit</li> <li>• information and training of clinical staff on the Prison Service's multi-disciplinary risk management process (ACCT Plan or F2052SH) for patients they identify as at particular risk of suicide or self-harm</li> </ul>
Fatal overdose on leaving prison	Opiate users particularly vulnerable to this risk due to diminished tolerance	<p>Substitute opioid management of dependence (sections 5.4 and 7)</p> <p>Effective continuity of treatment (sections 8 and 11)</p> <p>Overdose prevention information for patients</p>

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Risk area	Risk	Recommended management
Level of opiate dependence is uncertain	Non-dependent individuals may be at risk of opioid poisoning	<p>Clinical drug testing to include morphine, methadone and buprenorphine</p> <p>Use of opioid withdrawal assessment scale (eg short opiate withdrawal scale, Gossop 1990) and intoxication monitoring</p> <p>Ensure patient is fully alert, responding appropriately and that there are <b>NO</b> signs of drowsiness/sedation; withhold medication in the event of any concern</p> <p>Gradual dose induction, with doses divided (section 5.4)</p> <p>A minimum of twice-daily monitoring of withdrawal and intoxication during stabilisation</p> <p>Where benzodiazepine dependence is also diagnosed, diazepam should be prescribed at the lowest dose that will prevent withdrawal symptoms. Doses should be divided for at least the first seven days of treatment.</p> <p>Staff training in the administration of naloxone (section 6)</p>
Reduced opiate dependence in a newly received prisoner	Tolerance to opiates may have diminished following a break in consumption during police custody	<p>Clinical drug testing to include morphine, methadone and buprenorphine</p> <p>Use of opioid withdrawal assessment scale (eg short opiate withdrawal scale, Gossop 1990) and intoxication monitoring</p> <p>Ensure patient is fully alert, responding appropriately and that there are <b>NO</b> signs of drowsiness/sedation; withhold medication in the event of any concern</p> <p>Gradual dose induction, with doses divided (section 5.4)</p> <p>A minimum of twice-daily monitoring of withdrawal and intoxication during stabilisation</p> <p>Where benzodiazepine dependence is also diagnosed, diazepam should be prescribed at the lowest dose that will prevent withdrawal symptoms. Doses should be divided for at least the first seven days of treatment</p> <p>Staff training in the administration of naloxone (section 6)</p>

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Risk area	Risk	Recommended management
Increased risk on second and third day of opioid stabilisation	Cumulative toxicity due to filling of tissue 'reservoirs'	<p>Clinical drug testing to include morphine, methadone and buprenorphine</p> <p>Use of opioid withdrawal assessment scale (eg short opiate withdrawal scale, Gossop 1990) and intoxication monitoring</p> <p>Withhold medication in the event of any concern</p> <p>Gradual dose induction, with doses divided (section 5.4)</p> <p>A minimum of twice-daily monitoring of withdrawal and intoxication during stabilisation</p> <p>Where benzodiazepine dependence is also diagnosed, diazepam should be prescribed at the lowest dose that will prevent withdrawal symptoms. Doses should be divided for at least the first seven days of treatment</p> <p>Staff training in the administration of naloxone (section 6)</p>
Varied individual responses to substitute opioid medication	<p>Response may be affected by:</p> <ul style="list-style-type: none"> <li>• impaired liver function – history of injecting drug use, heavy alcohol use or hepatitis</li> <li>• individual variation in enzyme activity</li> </ul>	<p>Carry out liver function test where liver compromise is suspected</p> <p>Clinical drug testing to include morphine, methadone and buprenorphine</p> <p>Use of opioid withdrawal assessment scale (eg short opiate withdrawal scale, Gossop 1990) and intoxication monitoring</p> <p>Ensure patient is fully alert, responding appropriately and that there are <b>NO</b> signs of drowsiness/sedation; withhold all central nervous system depressant medication in the event of any concern, pending medical reassessment</p> <p>Gradual dose induction, with doses divided (section 5.4)</p> <p>A minimum of twice-daily monitoring of withdrawal and intoxication during stabilisation</p> <p>Where benzodiazepine dependence is also diagnosed, diazepam should be prescribed at the lowest dose that will prevent withdrawal symptoms. Doses should be divided for at least the first seven days of treatment</p> <p>Staff training in the administration of naloxone (section 6)</p>

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Risk area	Risk	Recommended management
Drug cautions and contraindications		<p>Opioid prescribing is contraindicated for patients with either acute respiratory depression or paralytic ileus</p> <p>Caution required in cases of hepatic impairment, renal impairment and recent head injury</p> <p>Extend frequency and duration of monitoring as necessary</p> <p>Consult British National Formulary (BNF)</p> <p>In complex cases, seek specialist advice</p>
Drug interactions	Effects of opioid medication may be enhanced or reduced by concurrent medication	<p>As drug cautions and contraindications above</p> <p>Refer to drug interactions chart, Annex 14 of DH (1999)</p> <p>See also <b>Appendix A</b> of this document</p> <p>Seek specialist advice when required</p> <p>Extend frequency and duration of monitoring as necessary</p>

Risk area	Risk	Recommended management
<p>Diversion of prescribed medication (high black market value in prison relative to the community)</p>	<p>Patients may be subject to intimidation</p> <p>Medication may be diverted to naïve individual</p>	<p>Supervise consumption of controlled drug and other drugs subject to misuse within prison</p> <p>Administer buprenorphine as follows:</p> <ol style="list-style-type: none"> <li>1. The oral cavity (including the area under the tongue) is examined prior to administration to ensure that no substitute 'tablet' or other foreign objects are concealed there</li> <li>2. The patient should consume some water</li> <li>3. The tablet or tablets are put under the patient's tongue by a member of staff who remains in the same room as the patient throughout the administration process</li> <li>4. The patient is observed throughout the dissolving phase, with at least one check during this process to ensure that the medication remains under the tongue</li> <li>5. The observing member of staff confirms that the medication has dissolved completely</li> <li>6. The patient should consume a drink of water</li> </ol> <p style="text-align: right;">Prison Health (2004)</p> <p>Guidance on the circumstances under which buprenorphine may be crushed can be found on <a href="http://www.pjonline.com/editorial/20050402/society/p401crushing.html">www.pjonline.com/editorial/20050402/society/p401crushing.html</a></p> <p>Supervise consumption of methadone followed by the administration of at least 200ml of water</p>



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Risk area	Risk	Recommended management
Observation inhibited by locked cell doors	<p>Suicidal behaviour/serious self-harm risk exacerbated by unmanaged withdrawal</p> <p>Overdose difficult to identify within these circumstances</p>	<p>Where possible, fit cell doors with healthcare hatches; these hatches should ordinarily be kept open at all times</p> <p>Involve patients in purposeful activity (including psychosocial interventions) with adequate time out of cell</p>
Vulnerability of stimulant users	<p>Acute intoxication may cause cardiac or cerebrovascular events</p> <p>Sudden lowering of mood may trigger suicidal ideation and self-harm attempts</p>	<p>Clinical team should daily monitor stimulant users who test positive for stimulants in reception for the first three days of custody (incorporating blood pressure and neuro-observation)</p> <p>Encourage users to engage in psychosocial interventions</p>
Care delivered by both specialist and non-specialist practitioners	Varying levels of competence can result in inappropriate treatment	<p>Protocol system for assessment and prescribing, validated by primary care trust/prison partnership clinical governance committee</p> <p>Give non-specialist practitioners access to specialist advice</p> <p>Ongoing clinical training and supervision programme</p>
Very high volume of treatments in local prisons	Misidentification of patients; duplication of drug administration	<p>Consistent with good planning practice, include photographic or biometric identification of patients in the drug administration process</p> <p>All opioid drug administration to be observed and witnessed, both parties to sign the relevant documentation, the patient to sign as well to agree that they have received the medication</p> <p>Healthcare staff should verify patient details when arranging continuity of a community prescription (section 8)</p>

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Risk area	Risk	Recommended management
Lay staff on residential units may not recognise symptoms of withdrawal or intoxication	Clinical team may not be made aware of patients requiring urgent clinical attention	<p>Provide awareness and referral training for residential staff</p> <p>Draw up protocols to facilitate communication between clinical and lay staff (SECURE CD-ROM)</p>
Management of drug dependence in pregnancy	Poorly managed withdrawal may result in clinical complications	<p>Manage patient with divided doses for as long as necessary</p> <p>Contact community midwife immediately (section 14.2)</p>
Impact of substance withdrawal on patients with a mental health problem	Patients may experience a re-emergence or exacerbation of mental distress	<p>Pace prescribed management to minimise psychological duress</p> <p>Implement shared care planning arrangements between healthcare, mental health and CARAT teams (section 13)</p>
Disposal of drugs	Need for safe disposal of drugs	<p>NHS Estates will shortly be issuing guidance on the safe disposal of healthcare waste, including returned and surplus medicines. Interim guidance for pharmacists appears on the Royal Pharmaceutical Society of Great Britain website:</p> <p><a href="http://www.rpsgb.org.uk/pdfs/hazwastecommphguid.pdf">www.rpsgb.org.uk/pdfs/hazwastecommphguid.pdf</a></p> <p><a href="http://www.rpsgb.org.uk/pdfs/hazwastehospphguid.pdf">www.rpsgb.org.uk/pdfs/hazwastehospphguid.pdf</a></p>

### 3 Reception screening process

- 3.1 A new healthcare screening process has been introduced across all prisons that take offenders from court. The purpose of reception screening for substance misuse is to enquire about drug and alcohol use, and to screen for evidence of dependence in those who report current or recent use. Secondly, reception screening seeks to determine immediate healthcare needs, including withdrawal, for which there should be access to adequate and effective prescribing by a doctor for management upon reception into local prison custody. Wherever possible, location should be in a unit that offers access to unrestricted observation at all times 24 hours a day by healthcare staff trained in substance misuse. This observation is best made through open healthcare hatches (HM Prison Service 2000). Healthcare hatches are recommended for initial accommodation for prisoners as they can afford a level of observation that includes visual, oral, auditory, olfactory and tactile communication and monitoring. A system based on agreed protocols should provide management options at this phase of custody. Prisoners who are primarily or exclusively stimulant users should also be provided accommodation in a unit that offers enhanced observation.
- 3.2 Reception screening has to be brief and, in a local prison, should be focused to ensure that appropriate prescribed clinical management is undertaken by a doctor upon reception. In cases of opiate dependence in local prisons, this should be the commencement of a period of prescribed stabilisation, with an opiate agonist. Commissioners may decide to meet this requirement by contracting a doctor into reception or through an on-call system. Where the latter is provided, there must be provision for the doctor to visit the prison, assess and prescribe for the patient. There should be enough time and resources for the doctor to make an adequate assessment. This option would normally be preferred for those arriving 'out of hours'.
- 3.3 There are methodological problems facing the assessing doctor. Prison/primary care trust partnerships should therefore devise systems to improve this process – for example, consistent clinical recording, accurate drug screening tests, and nurses and healthcare workers trained in substance misuse to assist in the assessment and recording process. It may also be useful to investigate ways of improving communication between the prisoner's GP and the assessing doctor.
- 3.4 Knowledge and information should be provided during initial assessment about what will occur during the withdrawal process and a reassurance given that the service is available to support the individual in an active management regime. For those patients progressing to detoxification, knowledge and awareness of the withdrawal process significantly reduces stress and improves overall outcome. Written information should be more generally available and should include information on both the choice and length of treatment, consequences – both physical and psychological – of withdrawal, and the potential benefits of seeking help in coping with these experiences. Plainly expressed warnings regarding the risks of overdose should also be provided – in pictorial and written form.

- 3.5 In the initial stage, drug testing is critical to establishing current opiate or other drug use. It is particularly important to establish the presence of morphine or other opioid metabolites where a self-report of opioid use has been made. Where they are available, CJIT assessments that include Class A drug test results should be incorporated into the assessment procedure. In circumstances where a drug screen does not detect opiates, clear signs of withdrawal must be observed before medicated management is considered. A validated opiate withdrawal scale, such as the short opiate withdrawal scale (Gossop 1990), should be used to determine the presence of withdrawal. Withdrawal from benzodiazepines and alcohol may complicate the clinical picture and caution is recommended in cases of uncertainty. Subsequently, clinical drug testing can be used to monitor further use of non-prescribed drugs.
- 3.6 Staff should be aware of the psychological effects of nicotine withdrawal, which include agitation and impulsiveness.

### 4 Assessment

- 4.1 The clinical assessment following reception should be undertaken by a competent nurse, pharmacist or doctor. It should include a full drug use history, including past and current injecting (with inspection of injection sites and abscesses), and details of current community treatment. As continuity of care is central to effective treatment, healthcare teams should use the revised DIR as the initial (ie 'triage') substance-misuse assessment document. This will facilitate entry into the Integrated Drug Treatment System for prisons and access to continued care through the Drug Interventions Programme (National Treatment Agency 2005). The healthcare practitioner should complete the DIR up to and including the healthcare section and pass the form to a member of the CARAT team for its completion. It is essential that there is accurate documentation of this assessment entered in the patient medical records. When a prisoner states that they are on a community treatment programme, corroborative prescribing information should be sought (see section 8). It will be necessary to stabilise prescribing (see section 5.4) while the answer from the community clinician is awaited. Chief pharmacists within primary care trusts can help to locate community treatment information.
- 4.2 Substance misusers are particularly prone to a number of medical conditions. These include viral hepatitis, HIV, bacterial endocarditis, tuberculosis, septicaemia, pneumonia, deep vein thromboses, pulmonary emboli, abscesses, thrombophlebitis, dental disease, seizures and other neurological impairments. Planned management, including specialist referral where indicated, is appropriate in such cases. Ongoing clinical monitoring is valuable as the early symptoms of drug withdrawal may mask a separate underlying physiological condition.
- 4.3 Practitioners should elicit information on exposure to blood-borne viruses, sexual health risks, and lead on to referral to the appropriate service. The potential need for a mental health assessment should form part of the assessment process. Where suicidal ideation is detected, the Prison Service's multi-disciplinary risk management process (Assessment, Care in Custody and Teamwork or F2052SH) should be instigated. Other clinical interventions may be corroborated by the relevant community services (eg continued management of deep vein thrombosis and infection management). The opportunity to vaccinate against hepatitis B should be maximised.
- 4.4 The assessment process should also be used to develop a map of the journey for this particular treatment episode. Part of this function should be to help the individual develop some personal aims and objectives for managing their substance misuse. A substantial amount of behavioural change can be encouraged by the prison regime and the move into a structured environment away from high-risk drug-taking situations in the community. Prison does, however, have its own problematic drug culture.

- 4.5 The setting in which clinical management occurs varies between establishments. In some, it will occur within a healthcare unit, while others may have a dedicated wing. Those patients with a mild dependence (who would be managed as outpatients in the community) may be accommodated at a residential location provided there are no other medical complications and that observations may be carried out by healthcare staff, trained and competent in substance misuse, in accordance with Prison Service Order 3550 (HM Prison Service 2000). Newly received prisoners need to be made aware of the setting in which stabilisation and further clinical management occurs within that prison. This will include obtaining informed consent from the patient for the sharing of essential health information with key staff involved with their care, on a need-to-know basis. This environment should, wherever possible, permit unrestricted observation by healthcare staff 24 hours a day for at least the first five days of clinical management, and beyond this period where withdrawal is complex. Where they have been installed, healthcare hatches should be kept open to facilitate this observation, as described in section 3.1 above. When new builds or refurbishments are undertaken, these facilities should be created.
- 4.6 Patients undergoing medicated management of their substance misuse who leave the prison under temporary licence or under intermittent custody should be reassessed when they return.
- 4.7 All prescribed regimens should be supported by evidence, and conform to Prison Service Order 3550 and the Department of Health's clinical guidelines (1999), in accordance with the principles of clinical governance, such as good record keeping, clinical audit and significant event recording. It is important to reassure new prisoners and make the process of assessment transparent, easily understandable and with a goal of reducing the level of arousal and anxiety associated with the early stage of imprisonment.

### 5 Opioid prescribing: stabilisation

For the purpose of this document, the term 'stabilisation' means the moderating and control of withdrawal symptoms for a given period of time. In prison, this would be for a minimum of the first five days of custody, which is a period of high risk of suicide and self-harm. Stabilisation is achieved through a process of dose induction – the gradual introduction of doses of either methadone or buprenorphine in response to withdrawal symptoms. Dose induction is usually completed within 48 to 72 hours, at which point the current daily dose would be continued until at least day five, when a decision would be reached on future clinical management.

- 5.1 Opiate-dependent prisoners should be stabilised on licensed opiate substitute medication for a minimum of five days to enable withdrawal symptoms to be adequately controlled. This period also permits time for input from professionals from both within the community and the prison to inform a decision on whether to proceed to detoxification or maintenance, taking into account the wishes of the patient. Detailed assessment and care planning should be developed over this five-day stabilisation phase. Effective management withdrawal symptoms, within the context of a minimum of five days' 'unrestricted' observation (with healthcare hatches open where they have been installed), may reduce the possibility of impulsivity associated with self-harming behaviours, and detect it more easily when it occurs.
- 5.2 Patients must be monitored frequently during the stabilisation and detoxification phases to ensure that symptoms are controlled – in the past patients have died as a consequence of uncontrolled vomiting during detoxification in prison. If this symptom persists beyond a period of 24 hours, the patient must be transferred to an outside hospital. Clinicians need to be cautious where the patient is also on other prescribed medications such as tranquillisers and antidepressants, as these may precipitate central nervous system depression.
- 5.3 The four main purposes particular to prescribing methadone or buprenorphine in prison are:
  - to provide a gateway to community substitute treatment for those who request this as a treatment option, assuming that this can be continued upon release back into the community;
  - to continue community methadone or buprenorphine prescribing programmes that will, in turn, be re-established following release ('clinical throughcare'). There is good evidence that engagement with community specialist drug programmes may have beneficial effects on health and on offending behaviour (Mattick et al 2002);
  - to increase tolerance to opioids, which reduces – but by no means eliminates – the risk of fatal drug overdose upon release from prison;
  - to reduce self-harming and suicidal behaviour among prisoners with a chronic drug dependence.

5.4.1 **Fatalities from methadone poisoning have been reported at doses as low as 20mg (Humenuk et al 2000).** Non-opiate-dependent individuals are at risk from doses as low as this, and the risk is exacerbated when the simultaneous prescription of a benzodiazepine is necessary. Methadone deaths tend to occur on the second or third day of treatment as a result of cumulative toxicity. These deaths occur as a consequence of inadequate assessment, failure to confirm previous opiate use by clinical testing for drugs, failure to confirm dependence (such as treatment in the absence of withdrawal symptoms) and a lack of monitoring.

5.4.2 Deaths also occur as a result of concomitant administration of other drugs, and drug interactions (BNF 2005).

5.4.3 Such tragedies can be avoided by adherence to the following principles of treatment:

- An adequate assessment of past history.
- An opioid-positive drug test result.
- Where there is doubt regarding the presence of dependence, a prescription is to be made only in the presence of **objective** signs of opioid withdrawal, which are:

Sweating

Yawning

Anorexia

Tremor

Insomnia and restlessness

Tachycardia, hypertension

Dilated pupils

Lachrymation and rhinorrhea

Feeling hot and cold

Abdominal cramps

Nausea, vomiting and diarrhoea

Generalised aches and pains

Gooseflesh

Increased bowel sounds

(DH 1999)

- Gradual dose induction in increments of 5 to 10mg methadone (methadone mixture, 1mg in 1ml).
- Regular monitoring of the patient and, in the event of any sign of drowsiness, the withholding of the due dose of methadone and any other sedating medication pending reassessment.
- Supervised consumption of prescribed methadone followed by the administration of at least 200ml water to reduce the potential for diversion.

5.4.4 Methadone has a variable half-life that can be as long as 25 hours. However, a peak plasma level occurs at 2 to 4 hours after an oral dose. It is therefore wiser to commence stabilisation by the use of small doses spaced at intervals. This will help to prevent any initial accidental overdose in those who are susceptible or prove to be opiate naïve despite other tests and clinical signs to the contrary. Any indication of over-sedation/drowsiness must result in the nurse withholding methadone and other central nervous system depressant medicines pending medical reassessment.



- 5.4.5 Patients should be subject to enhanced observation over the first five days of methadone treatment.
- 5.4.6 **Risk factors:** A large remand prison will need to assess and stabilise 200 or more new patients per month, a rate unknown in any other clinical substance misuse setting. Dose induction is made more complicated by the unusual dynamic of treatment being offered to an individual who has not requested it, the possibility of reduced tolerance following a break in consumption during police custody, observation inhibited by locked cell doors and the involvement of non-specialist clinical colleagues in the delivery of care.
- 5.4.7 To ensure patient safety within this context, **methadone treatment programmes should be established through a process of dose induction. Initial doses of five to ten milligrams of methadone (1mg in 1ml mixture) are to be given, at least six hours apart.** This rule also applies to the continuation of most community methadone programmes (see section 8 of this document for guidance on this area of practice).
- 5.4.8 Where the above regimen appears to be insufficient to manage a patient's withdrawal, a substance misuse specialist doctor (primary care or other background) with experience in local (remand) prison practice may personally prescribe doses titrated against withdrawal in addition to this regimen, taking full account of the clinical **risk factors** described above.
- 5.4.9 As a further safeguard for the patient, and as a means to minimise the potential for diversion and its attendant risks, **the standard maximum recommended maintenance dose of methadone prescribed in prison is 40mg per day.** The risk of fatality among naïve consumers above this dosage is the reason for this cautious and conservative approach. This recommendation will be reviewed in the light of future clinical findings in the prison setting.
- 5.4.10 In the event of a patient continuing to experience difficulties at 40mg methadone, additional gradual titration of between 2 and 10mg per day may be indicated. This should only be prescribed under the guidance of a doctor with specialist addiction training<sup>1</sup> who has had 70 hours' experience of working in a prison of a similar category.<sup>2</sup> A consultant in addiction psychiatry may also prescribe beyond 40mg once they have had the opportunity to familiarise themselves with practice in prison. Where prescriptions are substantially in excess of 40mg per day, divided dosing may be preferred.

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1 That is, a substance misuse specialist doctor (primary care or other background). The prison environment presents clinical challenges that are uncommon in other settings (see section 2), and it is for this reason that practice experience in prison is required.

2 In view of the significant differences in the operation and clinical issues encountered between remand (local) and training prisons, a specialist will need a further period of 35 hours to become familiar with the issues of moving from one category of prison to another.

- 5.5 Stabilisation of opioid withdrawal may be achieved via buprenorphine. Induction onto buprenorphine can be more difficult than methadone in the initial phase of clinical management. It is therefore recommended that methadone should be used to stabilise the opioid withdrawal of all dependent patients. Exceptions to this should be made when they are in the patient's better interests. These circumstances include:
- mild cases of dependence of the type that may be found among younger non-injecting heroin users;
  - patients who declare that they are currently prescribed buprenorphine as part of a community programme;
  - patients who express a preference – with which the clinician agrees – for buprenorphine.
- 5.6 As a prelude to buprenorphine induction, liver function tests should be undertaken as a baseline. Treatment may commence prior to the receipt of any results. The patient must be advised that the partial agonist properties of buprenorphine may exacerbate rather than reduce withdrawal symptoms in the event of recent or current opioid use. Patients should therefore have been heroin-free for 12 hours and methadone-free for at least 24 hours prior to the initial dose of buprenorphine. They should also be exhibiting clear signs of opiate withdrawal (RCGP 2003). Adjunctive symptomatic support or additional buprenorphine may be required in the early stages of treatment. The (sub-lingual) administration of buprenorphine demands close observation, as diversion ('palming') of tablets is a common problem. Should this happen, the buprenorphine programme should be discontinued and a clinically appropriate contingency regimen initiated while the patient's treatment is reviewed by the clinical team and a treatment intervention appropriate to the individual's need is introduced. It is particularly important that the alternative regimen is not deemed to be punitive.
- 5.7 Equivalence of treatment with community services necessitates that active clinical management of the effects of withdrawal symptoms is provided. Adjunctive treatment of symptoms should be regarded as part of active clinical management. Vomiting and diarrhoea should, therefore, be managed by effective prescribing of carefully monitored antiemetic and antidiarrhoeal medication, with transfer to an outside hospital if symptoms are not adequately controlled within 24 hours. Where there is a clear indication earlier than this that dehydration or other medical complications such as a diabetic crisis are developing, transfer to an outside hospital should be arranged immediately. Intractable vomiting associated with withdrawal has been fatal on occasions in prison.
- 5.8 Malnutrition, anorexia, hypothermia and hypoglycaemia are common problems during the early stages of drug withdrawal. Patients must have access to food, naturally sweetened drinks, adequate fluids and extra blankets during this phase. Additional food (and fluids) at night are necessary during the recovery phase of withdrawal, when the appetite returns and sleep problems occur.

- 5.9 Insomnia is one of the most common symptoms of opiate, alcohol and benzodiazepine withdrawal. Protracted sleep loss has a detrimental effect on thought, mood and behaviour. Insomnia should therefore be regarded as a potential risk factor for self-harm and suicide. It is recommended that a range of non-pharmacological interventions should be available to patients experiencing insomnia. Relaxation classes and other approaches to engender relaxation may be of benefit. In-cell radio or television should be provided but not charged for during the detoxification phase. Prescription of hypnotics should not be necessary during the stabilisation phase. If, as reduction progresses, insomnia becomes a problem, a short-acting hypnotic may be prescribed for a limited period and reviewed according to patient response. It should be borne in mind that these drugs are in themselves dependence forming and liable to be abused in the prison setting. The possibility of interaction between opiate agonists and hypnotics should also be considered when deciding on treatment.

# 6 Management of opiate overdose

6.1 **Opiate overdose** is characterised by:

- constricted (pinned) pupils (although dilation can occur);
- respiratory depression/cyanosis;
- pulmonary oedema (frothing from the lung);
- sweating;
- hypotension and bradycardia;
- unconsciousness.

6.2 Opiate overdose should be treated by resuscitation with oxygen.

6.3 Emergency administration of 0.8 to 2mg naloxone should be given I/V or I/M and repeated as necessary on account of its short half-life relative to heroin and methadone.

6.4 **In an emergency, naloxone may be administered by parenteral injection by any competent member of the healthcare team (HMSO 2005).**

6.5 An emergency ambulance transfer to an outside hospital must be arranged. The patient must be observed closely for 24 hours following return from hospital, as a secondary episode of respiratory depression can follow the discontinuation of naloxone treatment.

6.6 In the event of a suspected buprenorphine overdose, substantially more naloxone may be required.

# 7 Opiate agonist maintenance

- 7.1 Both methadone and buprenorphine maintenance are at present infrequently provided in English and Welsh prisons. Community maintenance programmes should be continued in prison following stabilisation, unless the patient or the existing community prescriber indicate otherwise. To ensure continuity of treatment upon release, referral to community services should be made through the CARAT team. Where there is a need to secure urgent continuity of clinical management out of CARAT office hours, it is the responsibility of the prison healthcare team to ensure that a community prescriber is notified of a patient's discharge from prison.
- 7.2 For detailed direction on the prescribing of methadone, see section 5.4 of this document.
- 7.3 The recommended upper dose of buprenorphine is 8 to 16mg per day. In exceptional circumstances, this may be increased to a maximum of 32mg where buprenorphine is a single agent. Where there is concurrent prescribing of benzodiazepines (or other central nervous system sedative drugs), there is a risk of respiratory depression, and prescribing should therefore take this into account for both buprenorphine and methadone.
- 7.4 Patients whose withdrawal symptoms have been stabilised using methadone may be transferred to buprenorphine through the staged reduction of their methadone to 20mg per day. Following a break of at least 24 hours, and upon observation of signs of opiate withdrawal, buprenorphine may be introduced at a dose of 4mg per day on day one.
- 7.5 Methadone or buprenorphine maintenance should be linked to ongoing support, including educational and occupational rehabilitation. In many instances, after a period of maintenance individuals will elect to withdraw. They should be permitted to do so at a rate with which they feel comfortable and that is manageable on an outpatient basis. As a patient nears their date of release, any reduction achieved should be reviewed, with the patient being made aware that a dose that has proven adequate in prison may be insufficient when they are released. Consideration may then need to be given to raising the dose of methadone back to the previous maintenance level before discharge. Some individuals will elect to withdraw completely to enable them to pursue a drug-free rehabilitation, either in prison or back in the community.
- 7.6 All individuals with a history of dependent opiate use who are received into custody on a short sentence (ie up to approximately 26 weeks) should be given the option of continued maintenance following stabilisation. A community prescriber should be located to ensure that treatment continues upon release. An absence of injecting drug use – a pattern that is common among opiate-dependent members of the black and minority ethnic community – should not preclude entry to a maintenance programme (Sangster et al 2002). Where there is a high likelihood of a patient returning to injecting opiate use upon release, but no community prescribing services can be accessed, maintenance should

be provided on the grounds of post-release overdose protection. Random clinical drug testing for illicit drug use should form part of any maintenance programme.

- 7.7 A chronic opiate user who is received into custody on remand should also be offered a maintenance methadone prescription; a community prescriber should be located for that individual. Where a period of remand extends beyond 13 weeks, members of the drug treatment (ie CARAT and healthcare) team should review the maintenance programme. As with sentenced drug users, where there is a high likelihood of a patient returning to injecting opiate use upon release, but no community prescribing services can be accessed, maintenance may be provided on the grounds of post-release overdose protection.
- 7.8 For guidance on the continuation of community methadone programmes, see section 8.

# 8 Continuation of methadone programmes

- 8.1 To ensure safety, patients arriving in prison who are currently receiving a community methadone prescription should be treated in accordance with the standard dose induction regimen (as per section 5.4 above).
- 8.2 Continuation of methadone programmes at the existing community dose may only be provided in circumstances that meet all of the following criteria:
- The patient is receiving methadone under supervised consumption conditions.
  - The patient has been receiving methadone regularly for the previous seven days.
  - The patient last had their full supervised dose of methadone within the past 48 hours.
  - The patient's treatment details have been verified with the prescribing doctor and the supervising pharmacist.
- 8.3 In cases that meet all of the above criteria, the following regimen should be followed:
- **First night:** Assuming the patient has had their methadone on the day of arriving in prison, no further doses will be given. The patient should be drug tested and must be positive to methadone metabolites.
  - **Next day (day 2):** Confirmation needs to be obtained from the prescribing doctor/drug service of the dose and duration of methadone treatment. Where the location of the community pharmacist is unknown, the chief pharmacist within a primary care trust may be able to identify the correct practitioner. A brief description of the patient should be sought from the pharmacist to verify correct identity. (To protect patient confidentiality, mechanisms should be put in place to ensure pharmacists can confirm the identity of the healthcare team they are talking to before giving out this information.) As a further safeguard, it is recommended that the first two days' doses of methadone be evenly divided in two, with at least six hours' gap between the supervised administration of each dose.
- 8.4 In view of the universal use of supervised consumption of methadone in prisons, it is anticipated that patients on methadone programmes transferring between prisons will meet all the criteria set out in section 8.2 above. In such cases, treatment should be continued at the existing dose.

# 9 Detoxification

## Opiate

- 9.1 In respect of opiate detoxification, the decision as to when and by which pharmaceutical agent detoxification will be provided should be made on the basis of a combination of three factors:
- the patient's severity of dependence;
  - the patient's wishes;
  - the opinion of practitioners involved in the patient's care, both in the community and within the prison.
- 9.2 Following a minimal five-day stabilisation on either of the above two agonists, detoxification should routinely be for a minimum of 14 days if withdrawing from a short-acting opiate but longer if withdrawing from methadone. Detoxification will often need to be for 21 days or more if methadone has been used regularly prior to arrest. Dosage should be adjusted as needed, in response to signs and symptoms of withdrawal. Overall, it is best to have minimum standard withdrawal periods, which can then be extended. However, in the context of severe polydrug and alcohol dependence, a more graduated individual approach will be necessary; the methadone regimen should remain stable while the alcohol detoxification is taking place. Such management can assist in reducing the risk of impulsive self-harming behaviour.
- 9.3 For patients who have been stabilised on buprenorphine, a buprenorphine detoxification involves a gradual reduction in doses over the course of at least two weeks. For patients who have been stabilised on methadone, a buprenorphine detoxification should not be commenced until the patient has reduced to 20mg methadone per day, with a minimal gap of 24 hours between the last dose of methadone and the initial 4mg dose of buprenorphine. The patient should be reviewed two to three hours later. If withdrawal symptoms have been precipitated, symptomatic medication should be prescribed. Following full conversion to buprenorphine, a minimum 14-day reduction regimen should be initiated.
- 9.4 Following the five-day stabilisation onto an appropriate level of either of the above agonists, patients may elect to undergo detoxification using a non-opiate agonist (ie lofexidine). For patients who have been stabilised on methadone, there should be a minimum break of 24 hours between their final dose of methadone and their initial dose of lofexidine. To control withdrawal, detoxification should ordinarily commence at 200 micrograms twice a day, increased daily as necessary in steps of 200 to 400 micrograms to a maximum of 2.4mg. This regimen may need to be adjusted in response to withdrawal symptoms, with higher doses needed by some patients at the early stages of opiate withdrawal. Lofexidine may cause bradycardia or hypotension in some patients. Blood pressure and pulse rates must therefore be checked prior to



the administration of each dose, two hours after the initial dose and daily as the dose is increasing for at least the first 72 hours of the detoxification regimen and for longer if there are abnormalities. If the patient shows indications of low blood pressure or slowed pulse, they should be advised to rest with feet elevated, and monitored until improvement is observed.

- 9.5 Practitioners should be aware that whatever the duration of detoxification, withdrawal symptoms will frequently persist beyond the cessation of all medication. It is important to provide support for individuals in the first few days after stopping an opiate agonist; at this time some individuals will require symptomatic relief, which may include the use of lofexidine (with blood pressure and pulse monitored as above). Where individuals are transferred from a withdrawal management unit to an ordinary, residential location, practitioners should ensure that the residential manager is aware of the increased risk and the need for their staff to provide support to the prisoner at this time.
- 9.6 Methadone or buprenorphine should never be prescribed to a patient who has produced a negative opiate-test sample, unless they exhibit clear objective signs of opiate withdrawal or there is evidence of a confirmed prescription. In the absence of either of these, it is preferable to use a non-opiate medication such as lofexidine.

### Alcohol

- 9.7 Assessment for alcohol withdrawal should begin in reception, as the first signs of withdrawal commence six to eight hours after an alcohol-dependent individual's last drink. Tremor is the earliest, most common and easily recognisable sign; seizures can begin in the first 24 to 48 hours.
- 9.8 Alcohol detoxification should be managed with chlordiazepoxide from the first night of custody. This should begin in reception. Common features of alcohol withdrawal include sweating, tremors, nausea, vomiting, hypertension and tachycardia.
- 9.9 A percentage of patients are at risk of more serious complications, such as delirium tremens and seizures. These two conditions are potentially fatal, so it is therefore essential that all prisoners who give a history of heavy alcohol consumption prior to their arrival in custody are assessed and, if necessary, should begin a chlordiazepoxide detoxification regimen in reception in accordance with PSO 3550 (HM Prison Service 2000). When making an assessment of alcohol dependence, it is important that the level of alcohol consumption is explored and details of the type of alcohol noted, including brand and – where possible – strength. An estimation of the units can be made from this information. Extra-strong beers/lagers and ciders contain 4 units per can, and an average-strength can contains 2.5 units. Malnutrition, particularly thiamine deficiency, can cause neurological damage. All patients who undergo alcohol detoxification should be routinely prescribed 200mg thiamine daily for a period of 28 days. If a patient does not require formal alcohol detoxification but has a recent history of heavy drinking, they should still receive thiamine

as a precautionary measure. Patients will also require sufficient fluids to reverse potential dehydration, and adequate calorific foods to protect against hypoglycaemia.

- 9.10 Where there is a previous history of alcohol withdrawal seizures, the chlordiazepoxide regimen will need to be paced to take account of this. For those who have a diagnosis of epilepsy, anticonvulsant medication should be continued, and may need to be increased during the first 14 days of withdrawal.
- 9.11 It is important that these individuals are monitored for the first seven days of their management, as they may suddenly deteriorate or may suffer an epileptic seizure.
- 9.12 In the treatment of concurrent opiate and alcohol dependence, no reduction in the opiate agonist should be attempted until the alcohol detoxification is complete.

**Please note that if a patient shows any signs of alcohol withdrawal during detoxification, additional doses of chlordiazepoxide should be given and its effectiveness observed. Should a patient's condition fail to stabilise, their transfer to a general hospital must be effected as a matter of urgency, as uncontained alcohol withdrawal is a potentially fatal condition.**

### Benzodiazepine

- 9.13 Assessment of benzodiazepine dependence should be informed by self-reported history, confirmed prescribing history (if applicable), withdrawal monitoring and drug testing. Please note that as benzodiazepine withdrawal may take more than 72 hours to set in, a negative drug test result should not automatically preclude the prescription of a benzodiazepine detoxification. The sudden cessation of benzodiazepines can lead to a recognised withdrawal state, where there is risk of seizures and other potential medical problems. These include psychosis, anxiety states, insomnia, nausea, headaches and tremor.
- 9.14 Withdrawal prescribing (ie detoxification) should be initiated on the day of admission where there is a history of benzodiazepine dependence from either a prescription or regular street use. Where clinical assessment indicates a previous history of regular benzodiazepine use sufficient in dose and (in particular) duration to suggest dependency, a benzodiazepine detoxification regimen should be prescribed. Each prison should have treatment guidelines for the management of benzodiazepine withdrawal in line with DH (1999) guidelines. These should be developed in conjunction with an NHS specialist.
- 9.15 In cases of co-dependency on any combination of alcohol, opiates and benzodiazepine, more than one reduction regimen may be required, with additional caution necessary due to the interaction of these drugs. A substantial level of clinical experience within prisons has shown that

low-dose chlordiazepoxide detoxification for alcohol withdrawal and a low-dose diazepam regimen for concurrent benzodiazepine dependence can be safely prescribed together, although there are limits to the levels of the combination. Beyond the acute alcohol withdrawal phase, the total diazepam-equivalent prescription should not exceed 30mg per day where a concurrent opiate substitute is being prescribed.

- 9.16 To reduce the risk of over-sedation, the diazepam should be prescribed in divided doses until a level of 20mg per day is reached. The benzodiazepine withdrawal is then gradual at a rate of no more than 2mg per week (BNF 2005, DH 1999). Where it appears that a patient who has been prescribed a benzodiazepine reduction programme may not be benzodiazepine dependent, a substance misuse specialist doctor (primary care or other background) with experience in prison practice should review the reduction regime. In view of the possibility of oversight occasioned by the very high admission rates to withdrawal management units, it is recommended that alcohol and benzodiazepine detoxification regimens be prescribed separately, utilising chlordiazepoxide and diazepam respectively. Alternatively, clinicians may wish to combine these two regimens using an increased level of chlordiazepoxide for the first seven days to cover both withdrawal regimens. There is a need to ensure that the longer-term prescribing required for benzodiazepine reduction is in place as the alcohol withdrawal phase is finishing. Benzodiazepine dependence and withdrawal can be associated with serious suicide and self-harming behaviours, and should be managed accordingly with due caution, which may in certain instances require a slower reduction than indicated above.
- 9.17 Where opiate agonist maintenance is being offered, detoxification from benzodiazepines may be undertaken as described above, but where concurrent detoxification from opiates and benzodiazepines is being undertaken, a more cautious approach to both will be required.
- 9.18 Patients with a confirmed history of epilepsy will require cautious rates of reduction for benzodiazepine dependence, informed by ongoing monitoring. An increase in the levels of any currently prescribed anticonvulsant medication may be required.
- 9.19 Where there are concerns that a patient may be diverting prescribed diazepam tablets, clinicians should consider the use of the alternative liquid formulation.
- 9.20 All aspects of clinical care of a patient with a substance misuse problem should be provided in accordance with evidence-based practice and within the context of the prison's clinical governance framework. Clinical supervision is an important means of supporting high-quality clinical practice.

# 10 Management of stimulant withdrawal

- 10.1 A prisoner who has a substance misuse problem but does not require clinical management of this problem should be admitted to the First Night Centre/ Induction Centre in local prisons where this provision exists.
- 10.2 Prisoners with substance misuse problems who are located outside of the withdrawal management unit should be observed for fluctuations in mood or behaviour. Among this group of prisoners will be stimulant users (including 'crack' users). Withdrawal from stimulants can cause marked swings in mood, leading to potential acts of violence towards self or others. A short but profound depression is a recognised withdrawal symptom, which may necessitate treatment. To reduce the risks associated with isolation, the prison regime should ensure that optimum time is available for purposeful activities.
- 10.3 Cocaine use is associated with a number of serious medical problems, particularly cardiovascular complications, including cardiac arrhythmias and myocardial infarction. Acute cocaine use increases the risk of stroke secondary to arterial vasospasm, thrombosis or hypertension. Sudden death occasioned by intracranial bleeding/thrombosis or cardiac arrest appears to be an increasing risk among young adults abusing crack. It is recommended that patients reporting recent heavy stimulant use and who test positive on admission to either cocaine or amphetamines are admitted to the withdrawal management unit, where neurological observations and blood pressure monitoring for signs of hypertension should be carried out for the first three days of custody. Any abnormalities would warrant full medical assessment, and in the event of continued concern, the patient should be transferred to an outside hospital. Particular attention should be given to any reports of headache or dizziness during this period. Where there is evidence of agitation or volatility in those withdrawing from stimulants, consideration may be given to short-term prescribed management of some of the symptoms of withdrawal.
- 10.4 Dual diagnosis is not uncommon among substance misusers in prison. The 1997 Office for National Statistics psychiatric morbidity study (Singleton et al 1997) identified five main mental health disorders. Some 54% of male remands, 44% of males sentenced, 61% of female remands and 42% of females sentenced were substance misusers and had three or more of these disorders.
- 10.5 An underlying serious mental health problem (such as schizophrenia) may appear in a newly drug-free phase. A full mental health assessment should be considered for any prisoner demonstrating signs of these problems. A full range of supportive resources (eg NHS, mental health in-reach services, Listeners and CARATs) should be available within the establishment to meet the needs of this group of prisoners. Concerns for a prisoner's safety as a consequence of their mental distress should result in the activation of the prison service's multi-disciplinary risk-management process (ACCT Plan or F2052SH).

- 10.6 The needs of stimulant users coming into prison should be addressed by their inclusion in the 28-day psychosocial intervention (see section 15), including access to specialist stimulant groups and relaxation classes. Continuity of service is central to good outcomes for stimulant users. Introduction to any community stimulant services within the prisoner's home area should therefore be provided.

# 11 Continuity of treatment

- 11.1 Consideration must be given to the needs of patients receiving prescribed management of drug dependence on a day when they are due to leave prison custody to attend court. All remand prisoners should receive their opioid substitute medication in the morning, prior to any attendance at court, to restrict the emergence of withdrawal symptoms if they are released later in the day. Local protocols should be negotiated between the prison, escort contractors and court administrators for the secure administration of medicines that are prescribed in more frequent doses. The relevant CJIT needs to be notified at the earliest opportunity when a patient who is part of the Drug Interventions Programme and is receiving clinical management of substance misuse is due to appear in court.
- 11.2 The period immediately following release is a time of considerable vulnerability. For patients leaving prison with existing prescribed management of their substance misuse problem, contact should be established with a community service at the earliest opportunity, so that an appointment may be made following release. Close working between the clinical and CARAT teams, the local CJIT or relevant community treatment provider is central to the securing of good integrated care. Where a patient leaves prison on a Friday, they may not be seen until early the next week. In such circumstances a community pharmacist should be located to provide an interim dispensing service. In the event of no pharmacy being available, a risk assessment should be conducted to help determine how much take-home medication should be issued to the individual. Routinely it is recommended that three days' take home medication is given. In the case of methadone this should be given in three separate bottles. On a bank holiday weekend, further days' medication may be required.
- 11.3 Provided that they are medically stable, patients who are on a maintenance opioid programme may transfer to a training prison. The receiving prison should continue treatment in line with the criteria set out in section 8 of this document.
- 11.4 Patients on a maintenance programme can transfer to open conditions after 28 days of commencement of clinical management. Again, treatment should be continued in accordance with section 8 of this document.

# 12 Administering of medications and nursing observation

- 12.1 There should be a minimum period of five days' observation of patients who are undergoing clinical management by nursing staff, and longer if abnormalities are detected. Wherever possible this should be 'unrestricted' with, where they are installed, healthcare hatches open in doors where detoxification is undertaken. A protocol should be in place to determine the circumstances when hatches may be closed. It is necessary to observe patients during the early phase of withdrawal either for withdrawal symptoms such as fitting, vomiting or distress or for side effects of medication such as a sudden reduction in blood pressure.
- 12.2 Staff should supervise the consumption of every dose of methadone or buprenorphine. All additional non-opioid medication should be consumed under supervision for at least the first 10 days of detoxification, to monitor efficacy and to allow doses to be adjusted accordingly. To enhance control of diversion it is further recommended that all doses of diazepam (or other benzodiazepine-based medication) be prescribed for supervised consumption only.
- 12.3 Methadone or buprenorphine should be administered by a registered nurse or pharmacist. A second member of staff should be present to act as a witness. Before administering methadone or buprenorphine, nursing staff must:
- check the identity of the patient;
  - ensure the patient is **fully alert** and responding appropriately, and that there are **no** signs of drowsiness/collapse, slurred speech, droopy eyelids or lowering of blood pressure;
  - consider whether there are any other reasons to suspect additional illicit drug use.
- 12.4 In the event of uncertainty regarding any of the above, the nurse must **withhold the methadone or buprenorphine and other sedating medication**, observe the patient, monitor blood pressure, notify a doctor and test for drug use.
- 12.5 Prison should have protocols for the management of drug overdose, including overdose of methadone.

### 13 Complex needs: dual diagnosis

- 13.1 Rapid withdrawal from drugs of dependence can upset a patient's mental equilibrium, heightening their risk of impulsive self-destructive behaviour. It is therefore recommended that a patient coming into custody with complex needs should be provided with clinical treatment to stabilise their withdrawal from opiate or benzodiazepine dependence. Consideration should be given at this early stage to the indication for opiate maintenance.
- 13.2 Details of the planned care provided by the patient's community mental health team (CMHT) and dual diagnosis services prior to custody should be established. The patient's informed wishes and the advice of community providers should be taken into account when clinical substance misuse care is planned. If detoxification is the preferred action, the opinion of the Royal College of Psychiatrists (Royal College of Psychiatrists 2002) is that a gradual reduction programme would be in the patient's best interests.
- 13.3 An integrated approach is recognised as the best way of managing patients with complex needs. This involves active consultation between CARAT, clinical substance misuse, primary healthcare and mental health teams.
- 13.4 All patients with a serious mental illness should be managed within the Care Programme Approach (CPA). This system requires the involvement of all significant parties, including the patients themselves, their families, community services, in-prison services and (where the patient is located on ordinary location) residential staff.
- 13.5 Patients received into prison with an existing CPA will have that CPA continued. In these cases, the mental health team within the establishment will discuss with the CMHT which service will provide a care co-ordinator.
- 13.6 For patients who have no history of mental health treatment but who demonstrate symptoms of serious mental illness, the mental health team within their establishment will need to initiate the CPA. Representation should be sought from the patient's home mental health service (CMHT), and this community team will be involved in the planning of all subsequent care.
- 13.7 While in prison, where there is less ready access to illicit drugs, a patient's mental state may appear quite stable. The release care plan needs to take into account the previous history of substance misuse, as the patient is liable to return to drug taking upon release. Similarly, any previous history of substance misuse must also be considered when a patient is transferred to another prison.
- 13.8 Some detoxification patients may show no signs of mental disorder until they reach an advanced stage in their withdrawal programme. This may be a delayed response to the withdrawal from substances that have antipsychotic properties; opiates, benzodiazepines, alcohol and even stimulants may have the capacity to limit the symptoms of psychosis experienced by individuals with serious mental



health problems. Timely and measured clinical intervention would help to contain these breakthrough problems.

- 13.9 Further guidance on the management of patients with a dual diagnosis in the prison setting will be published shortly.

# 14 Clinical management during pregnancy

- 14.1 Protocols should be agreed locally between the community obstetric services, the prison clinical team and the local specialist drug service on the management of a pregnant woman who is heroin or methadone dependent.
- 14.2 The aim of these will be to ensure a safe pregnancy with minimal withdrawal in the neonate. Upon arrival in prison, all pregnant women should be stabilised on methadone for a minimum period of two weeks. Drug dependency may be associated with amenorrhoea; therefore, a pregnancy test may need to be undertaken during assessment. A referral to the drug liaison midwife should be made immediately (assuming that the woman wishes to continue with the pregnancy) and probation services advised, as they will then contact the community social services department. If there are no existing antenatal records, a dating scan must be arranged to confirm the gestation of pregnancy. No changes to treatment should be made until this is known.
- 14.3 In accordance with DH (1999) guidelines, low-dose methadone maintenance should be offered, although a slow reduction in the mid-trimester may be offered if the patient prefers. There should not be any reduction in the first trimester, and maintenance is preferred in the third trimester. Some patients require an increase in methadone in the third trimester, and it may be necessary to provide this in daily divided doses. Where patients insist on continuing with a reduction regimen in the third trimester, this should be paced as slowly as possible: ideally no more than 1mg of methadone per week.
- 14.4 Methadone maintenance in place at the time of delivery should be continued indefinitely in the postnatal period, both for women who remain in prison with their babies and for those who are separated. This is in an attempt to stabilise the mother at this very vulnerable time, and then to allow her to re-engage with a local treatment agency upon release. (A community prescriber must be found prior to the patient's release, and these arrangements should be made well in advance to ensure continuity of treatment and support upon release.) If the patient wishes to reduce her methadone in the postnatal period and there are otherwise good supports, this can of course be undertaken, but with caution.

# 15 Open psychosocial support intervention

- 15.1 Detoxification and maintenance programmes are two of the key treatment modalities under models of care and therefore can be seen as interventions in their own right. However, they are also a gateway into a treatment journey for those clients who require ongoing psychosocial treatment/support to remain drug-free/stable.
- 15.2 Both pharmacological interventions and psychosocial treatment are more effective when they work together in an integrated and harmonised manner.
- 15.3 The Drug Strategy Unit document *Integrated Drug Treatment System: the first 28 days: psychosocial support* (National Offender Management Service 2006) describes how psychosocial services will be delivered for problematic drug users during the first 28 days of custody under the Integrated Drug Treatment System, as funding permits. The main aim of the psychosocial intervention is to provide a 28-day structured care package of psychosocial support for prisoners with problematic drug use which:
- complements clinical interventions;
  - takes into account previous treatment in the community or custody;
  - provides a platform for longer-term drug treatment in prison and on release.

# 16 Naltrexone

- 16.1 The option of naltrexone treatment should be available where requested and clinically indicated. Naltrexone may be prescribed following detoxification to those who require assistance to sustain abstinence from opiates
- 16.2 Naltrexone treatment should begin at least five days prior to release from prison. A doctor who is willing to continue prescribing in the community will need to be identified before treatment is initiated. Naltrexone alone will probably be insufficient to prevent a return to heroin addiction – it should be offered in conjunction with a community programme that addresses the social and psychological implications of drug dependence.
- 16.3 A liver function test is required prior to commencement of treatment. A full blood count test is additionally recommended. Serum aspartate aminotransferase (AST) levels may increase during naltrexone therapy. If a baseline liver function test shows AST at a level two or more times higher than normal, naltrexone treatment should not be commenced. It is recommended that patients with baseline abnormalities should have their bloods monitored every two weeks for the first six weeks of treatment, and once every month thereafter. It is recognised that this will ordinarily be in the post-release period and consequently the responsibility of a community prescriber.
- 16.4 If a patient decides to cease their naltrexone treatment, they must be strongly advised that they will have lost all of their former tolerance to opioids. Careful advice will therefore be required to stress that any return to heroin use must be at a considerably lower dose than at the height of the patient's previous consumption. While stressing the inherent risk in return to any form of heroin use, the danger of direct return to intravenous opiate use should be particularly emphasised.
- 16.5 As naltrexone will block any opiate analgesia, it is not indicated for patients who have chronic pain problems or are awaiting surgery. All patients commencing naltrexone treatment should be issued with a medical alert card. Patients should be cautioned against any attempt to overcome the blocking effect of naltrexone by the use of increasing amounts of heroin.
- 16.6 A patient who is physically dependent on opioids at the commencement of a course of naltrexone will be thrown into immediate and profound withdrawal upon taking their first tablet. To avoid any likelihood of this occurrence, it is recommended that:
- naltrexone treatment should not be initiated until a patient is 7 days clear of heroin or (because of its greater half life) 14 days clear of methadone;
  - a drug screen should confirm this opioid-free status;
  - treatment should commence with a naloxone 'challenge'.

- 16.7 A naloxone challenge involves the intravenous injection of 0.2mg of naloxone, followed by 30 minutes of observation. Any undeclared use of opioids that may have escaped detection via drug screening will become apparent. The withdrawal effects that this challenge can provoke are less acute and uncomfortable than those that would be engendered by oral naltrexone. If the patient shows no discernible reaction to this challenge, a second injection of 0.6mg should be given, and the patient closely observed for a further 30 minutes for signs and symptoms of opioid withdrawal. If no withdrawal effect becomes apparent, the patient is now clear to begin taking naltrexone. Following a successful naloxone challenge, an initial observed dose of 25mg (half a tablet) should be given. If there is no discernible reaction, the regular daily regimen of 50mg can commence on the following day.
- 16.8 In circumstances where venous access is poor but the clinician is confident that the patient is drug-free and has been so for the required preceding period (ie 7–14 days, dependent on the type of opioid last used), the clinician may give naltrexone as an oral challenge. The patient should be given a quarter tablet (12.5mg) of naltrexone and observed for two hours with a further follow-up outpatient appointment later the same day. If the patient demonstrates no discernible signs of withdrawal, he or she may be given a half tablet of naltrexone (25mg) on the following day. If again no problems occur, the full dose (50mg) of naltrexone can commence the following day.

# 17 Black and minority ethnic substance misusers

- 17.1 Access to prison drug services by black and minority ethnic (BME) prisoners is often very limited. Clinical teams should, therefore, monitor the utilisation of their service by this particularly disadvantaged group, as part of a process of monitoring service uptake by members of all diverse groups.
- 17.2 Ongoing links with local community organisations should be developed to help make services in prisons and the community more accessible. Areas that could be addressed to help BME patients include:
- active BME staff recruitment (Race Relations (Amendment) Act 2000);
  - active BME prisoner recruitment for Prisoner Advisory Drug Services;
  - staff training programmes;
  - the formulation and display of an anti-discriminatory policy in alliance with prison race relation teams (HM Prison Service 1997);
  - compilation of a directory of BME community services, including all faith groups;
  - links with interpreter services;
  - culturally relevant health promotion subject matter and materials;
  - particular regard to confidentiality issues;
  - establishment of specialist stimulant teams.
- 17.3 Further guidance on the successful engagement of BME drug users will be issued shortly.

# 18 Commissioning

- 18.1 It is recognised that some of the changes described in this document will have substantial funding implications.
- 18.2 The following is a summary of the clinical developments that will need to be planned through a joint commissioning framework:
- provision of prescribing for opiate withdrawal by a doctor in reception of a local prison;
  - introduction of five-day stabilisation via methadone or buprenorphine;
  - replacement of dihydrocodeine as a primary agent for detoxification;
  - extension of opiate detoxification to a minimum of 14 days;
  - clinical monitoring of stimulant users in the first three days of custody;
  - introduction of short-term (ie 13 weeks') opioid maintenance;
  - provision of adequate training and support for all clinicians working with substance misusers in prisons.
- 18.3 It may be anticipated that the uptake of clinical management will increase in response to an enhanced service provision. NB: Some prisons already provide one or more of the above enhanced services.
- 18.4 The Department of Health and the Home Office will be jointly funding the developments described in this document. Further guidance on commissioning the requisite elements of this integrated drug treatment system will be issued shortly.

# 19 Confidentiality and joint working

- 19.1 Joint working between healthcare and CARAT teams will be vital to reduce multiple assessments and duplication of work. It may be the particular wish of a patient that elements of their medical record remain a confidential matter between themselves and the healthcare department (blood-borne virus status or details of sexual health are possible examples of sensitive information). Equally, a CARAT client may wish details of their personal history or past offending to be kept as a confidence between the CARAT team and themselves. For these reasons, it is important that separate medical records and CARAT files are kept. However, all information necessary to provide the patient with care should be shared between these services to provide the patient with continuity of care. Similarly, all information necessary to safeguard the welfare of an at-risk patient who is to be released on licence should be shared with a probation team.
- 19.2 For further information, see Appendix C of this document.



### 20 Conclusion

- 20.1 This provides a vision of a schematic outline for approaches to the clinical management of substance misuse. None of these treatments are stand alone, but need to be delivered in a way that sees each stage as linked to the next, with the aim of promoting clear and coherent planned change that is self-driven and supported by the wider prison environment.
- 20.2 This document shall be reviewed within a year, in the light of any new research within the prison system, the improved training of prison doctors and the results of the National Institute for Health and Clinical Excellence guidance and technology appraisals of buprenorphine, methadone and naltrexone.

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# Appendix A: Methadone and buprenorphine drug interactions

## Methadone

Drugs that may interact with methadone to reduce its effects:

Drug	Function	Potential interaction	Note
Abacavir	Antiretroviral	Effects reduced	
Amprenavir	Antiretroviral	Effects reduced	
Barbiturates	Sedatives Anticonvulsants	1. Effects reduced 2. Enhanced central nervous system depression	Phenobarbital can lower methadone blood plasma levels. Seek advice
Buprenorphine	Opioid analgesic	Displacement of methadone	Can precipitate significant withdrawal effects
Carbamazepine	Anticonvulsant	Effects reduced	
Efavirenz	Antiretroviral	Effects reduced	
Naltrexone	Opioid antagonist	Methadone displaced	Clinically significant withdrawal effects
Nelfinavir	Antiretroviral	Effects reduced	
Nevirapine	Antiretroviral	Effects reduced	May precipitate opioid withdrawal
Phenytoin	Anticonvulsant	Accelerated methadone metabolism	Clinically significant reduction in methadone plasma levels
Rifampicin	Treatment of pulmonary tuberculosis	Accelerated methadone metabolism	Clinically significant – can cause severe withdrawal
Spironolactone	Diuretic	Effects reduced	

Drugs that may interact with methadone to increase its effects:

Drug	Function	Potential interaction	Note
Cimetidine	H2 antagonist for gastrointestinal conditions	Raised methadone levels	
Clarithromycin*	Antibiotic	Effects increased	
Erythromycin*	Antibiotic	Effects increased	

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Drug	Function	Potential interaction	Note
Fluvoxamine*	Selective serotonin reuptake inhibitor (SSRI) antidepressant	Effects increased	Other SSRIs may have a similar action
Ketoconazole	Antifungal treatment	Effects increased	
Moclobemide	Monoamine oxidase inhibitor (MAOI) antidepressant	1. Effects increased 2. Hypotensive and hypertensive reactions reported	Risk may apply to all MAOIs
Urinary alkalinisers	Treatment of renal conditions	Methadone retained	
Verapamil	Cardiac regulator	Effects increased	

Other interactions between methadone and prescribed drugs:

Drug	Function	Potential interaction	Note
Antihistamines (non-sedating)* – terfenadine, mizolastine		See*	
Antipsychotics* (including chlorpromazine, haloperidol, droperidol)	Treatment of psychosis	Enhanced sedative and hypotensive	Increased risk of toxicity with myelosuppressive drugs
Benzodiazepines	Sedatives/hypnotics	Enhanced CNS depression	
Domperidone*	Antiemetic	1. Methadone blocks gastrointestinal activity 2. Methadone effect could be accelerated but not increased	
Interferon (alpha) and ribavirin	Anti hepatitis C treatment	Side effects resemble opioid withdrawal	Methadone dose increase not necessarily indicated
Mexiletine	Cardiac regulator	Delayed absorption of mexiletine	
Nifedipine	Cardiac regulator	Increase in nifedipine	
Opioids	Analgesia	Addictive effects	Concomitant prescribing may cause over-sedation
Stavudine	Antiretroviral	Decrease in stavudine blood plasma level	Methadone levels unaffected
Tricyclics (amitryptiline, desipramine, imipramine, nortriptyline)	Antidepressants	Increased tricyclic toxicity	

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Drug	Function	Potential interaction	Note
Zidovudine	Antiretroviral	Zidovudine blood plasma level increased	

\* In rare cases, these drugs may interact with methadone to prolong the cardiac QT interval (Leavitt and Krantz 2003). See also section 9.4 (lofexidine detoxification).

### Buprenorphine

Drugs that may interact with Buprenorphine to reduce its effects:

Drug	Function	Potential interaction	Note
Carbamazepine	Anticonvulsant	Effects reduced	
Naltrexone	Opioid antagonist	Buprenorphine displaced	Clinically significant withdrawal effects
Phenytoin	Anticonvulsant	Accelerated buprenorphine metabolism	Clinically significant decrease in buprenorphine
Rifampicin	Treatment of pulmonary tuberculosis	Accelerated buprenorphine metabolism	Clinically significant – can cause severe withdrawal

Drugs that may interact with buprenorphine to increase its effects:

Drug	Function	Potential interaction	Note
Cimetidine	H2 antagonist for gastrointestinal conditions	Raised buprenorphine levels	
Clarithromycin	Antibiotic	Effects increased	
Erythromycin	Antibiotic	Effects increased	
Fluvoxamine	SSRI antidepressant	Effects increased	Other SSRIs may have a similar effect
Ketoconazole	Antifungal treatment	Effects increased	Clinically significant
Moclobemide	MAOI antidepressant	Effects increased Hypotensive and hypertensive reactions likely	Risk may apply to all MAOIs
Retonavir	Antiretroviral	Effects increased	Other protease inhibitors may react similarly

## Clinical management of drug dependence in the adult prison setting

Other interactions between buprenorphine and a prescribed drug:

Drug	Function	Potential interaction	Note
Antipsychotics	Treatment of psychosis	Enhanced sedative and hypotensive	Increased risk of toxicity with myelosuppressive drugs
Barbiturates	Sedatives Anticonvulsants	Enhanced CNS depression	
Benzodiazepines	Sedatives/hypnotics	Enhanced CNS depression	
Domperidone*	Antiemetic	Buprenorphine blocks gastrointestinal activity  Buprenorphine effect could be accelerated but not increased	
Interferon (alpha) and ribavirin	Anti hepatitis C treatment	Side effects resemble opioid withdrawal	Buprenorphine dose increase not necessarily indicated
Mexiletine	Cardiac regulator	Delayed absorption of mexiletine	
Opioids	Analgesia	Addictive effects	Concomitant prescribing may cause over-sedation or precipitate severe withdrawals

Based on data from the *British National Formulary* (British Medical Association and Royal Pharmaceutical Society of Great Britain 2005), Leavitt (2004) and Department of Health (1999).



# Appendix B: DANOS competences for healthcare team members

There are more than 100 Drug and Alcohol National Occupational Standards (DANOS) units, many of which are relevant to clinical substance misuse management in prisons.

The following is an outline of the most significant milestones of clinical management of substance dependence, matched to corresponding DANOS units.

Area of intervention	Section	DANOS unit
Initial healthcare screen	3.1	AA1: Recognise indications of substance misuse and refer individuals to specialists AF1: Carry out screening and referral assessment
Clinical drug test	3.5	AE1: Test for substance misuse
Initial (triage) substance misuse assessment	3.4 and 4.1	AF2: Carry out triage assessment
Interim care plan for up to the first five days of custody	4.1	AG1: Plan and agree service responses which meet individuals' identified needs and circumstances
Patient begins treatment (on the first night where clinically indicated)	3.4	AH6: Prepare and undertake agreed clinical activities with individuals in acute care settings
Medication administered to patient	5.4	AH2: Prepare and administer drugs as directed or prescribed by the clinician AH9: Supervise methadone (and other controlled drug consumption)
Patient may be at risk of suicide or a medical emergency as a consequence of withdrawal	5.4 and 9	AB5: Assess and act upon immediate risk of danger to individuals who have used substances AH7: Support individuals through detoxification programmes
Patient may be at risk of overdose throughout custody	6	AB5: Assess and act upon immediate risk of danger to individuals who have used substances
Formal care plan at five days	5.1	AF3: Carry out comprehensive substance misuse assessment AG2: Contribute to the development, provision and review of care programmes

## Clinical management of drug dependence in the adult prison setting

Area of intervention	Section	DANOS unit
Patient may be unaware of risks associated with substance misuse	15	AD1: Raise awareness about substances, their use and effects AB2: Support individuals who are substance users
Patient transfers to another prison or is released	11	AG3: Assist in the transfer of individuals between agencies and services
Patient is released	11	AH5: Undertake agreed clinical activities with individuals (such as initiation of a naltrexone programme) whose health is stable in non-acute care settings AH8: Dispense medicines and products

### Appendix C: Consent and confidentiality

For people to have the capacity to give informed consent to a clinical intervention, they must be able to comprehend and retain information that is material to their decision. They must be advised of the consequences of both having and not having the intervention in question, and have the time and capacity to use and weigh this information in the decision-making process.

Patients must be made aware that the information they give may be recorded, may be shared with their consent, in order to provide them with care, and may be used to support clinical audit and other work to monitor the quality of care provided.

In order to inform patients properly, staff must:

- a. check where practicable that information leaflets on patient confidentiality and information disclosure have been read and understood;
- b. make clear to patients when information is recorded or health records are accessed;
- c. make clear to patients when they are or will be disclosing information with others;
- d. check that patients are aware of the choices available to them in respect of how their information may be disclosed and used;
- e. check that patients have no concerns or queries about how their information is disclosed and used;
- f. answer any queries personally or direct the patient to others who can answer their questions or other sources of information;
- g. respect the rights of patients and facilitate them in exercising their right to have access to their health records.

There is a range of statutory provisions that influence the way in which patient information is used or disclosed. Details of these can be found on the Department of Health website at [www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4069253&chk=jftKB%2B](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4069253&chk=jftKB%2B)

The key principle of the common law of confidentiality is that information confided should not be used or disclosed further, except as originally understood by the confider or with their subsequent permission

While judgments have established that confidentiality can be breached 'in the public interest', these have centred on case-by-case consideration of exceptional circumstances. Confidentiality can also be overridden or set aside by legislation.

Under common law, staff are permitted to disclose personal information (to, for instance, a probation officer) in order to support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case-by-case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.

The Data Protection Act 1998 imposes constraints on the processing of personal information in relation to living individuals. It identifies eight data protection principles which set out standards for information handling.

In the context of confidentiality, the most significant principles are:

- the first, which requires processing to be fair and lawful and imposes other restrictions;
- the second, which requires personal data to be processed for one or more specified and lawful purposes;
- the seventh, which requires personal data to be protected against unauthorised or unlawful processing and against accidental loss, destruction or damage.

Within the Human Rights Act 1998 there is a requirement that actions that interfere with the right to respect for private and family life (eg disclosing confidential information) must also be justified as being necessary to support legitimate aims and be proportionate to the need.

Current understanding is that compliance with the Data Protection Act 1998 and the common law of confidentiality should satisfy Human Rights Act requirements.

From Department of Health (2003).

# Appendix D: Management of opiate overdose

**Opiate overdose** is characterised by:

- constricted (pinned) pupils (although dilation can occur);
- respiratory depression/cyanosis;
- pulmonary oedema (frothing from the lung);
- sweating;
- hypotension and bradycardia;
- unconsciousness.

Opiate overdose should be treated by resuscitation with oxygen.

Emergency administration of 0.8 to 2mg naloxone should be given I/V or I/M and repeated as necessary on account of its short half-life relative to heroin and methadone.

**In an emergency, naloxone may be administered by parenteral injection by any competent member of the healthcare team (HMSO 2005).**

An emergency ambulance transfer to an outside hospital must be arranged. The patient must be observed closely for 24 hours following return from hospital, as a secondary episode of respiratory depression can follow the discontinuation of naloxone treatment.

In the event of a suspected buprenorphine overdose, substantially more naloxone may be required.





