Drug Treatment Clinical Policy

January 2008

DRUG TREATMENT CLINICAL POLICIES

1.	Mission Statement	Pg 3
2.	Addiction Treatment Charter	Pg 4
3.	Clinical Interdisciplinary Care Planning	Pg 5
4.	Methadone Treatment Guidelines - Assessment – Treatment Plans & Treatment Goals - Induction - Maintenance - Detox	Pg 6
5.	Confidentiality Policy	Pg 27
6.	Criteria for Treatment Priority	Pg 29
7.	Central Treatment List	Pg 30
8.	Toxicology Screening of Urine	Pg 31
9.	Use of Methadone – Ordering, Dispensing, Administration and Recording of Methadone	Pg 34
10.	Management of Viral Infections	Pg 36
11.	Immunisation Guidelines	Pg 37
12.	HIV Testing	Pg 38
13.	Administration of HIV Medications	Pg 39
14.	Benzodiazepine Detoxification Guidelines	Pg 40
15.	Prescription of Hypnotics	Pg 43
16.	Lofexidine Guidelines	Pg 44
17.	Administration of Naltrexone	Pg 50
18.	Alcohol Policy	Pg 51
19.	Cocaine Treatment Policy	Pg 59
20.	Psychiatric Assessment of Substance Misuse Disorders	Pg 60
21.	The Assessment and Treatment of Pregnant Patients	Pg 61
22.	Use of Nutritional Supplements	Pg 63
23.	Nicotine Replacement Therapy	Pg 64
24.	Child Protection	Pg 65
25.	Monitoring and Evaluation	Pg 66
26.	Liaison and Transfer Arrangements between Community and Prison Drug Treatment Services	Pg 67
27.	Appendices	Pg 71

MISSION STATEMENT

The Irish Prison Service, in partnership with statutory and voluntary agencies, seeks to provide people in its custody with programmes to assist in the prevention, treatment, rehabilitation, and aftercare so as to minimise the harmful effects of substance misuse and prevent the spread of HIV, Hepatitis B & C, and other infections.

These programmes should be managed in the context of multidisciplinary working. In the prison context a multidisciplinary team consists of members of a number of professions (healthcare, prison management, probation, education, chaplaincy, etc.) who commit to using their complementary skills to a common purpose (the coordinated provision of services to prisoners with substance misuse problems). The team members are committed to a common purpose, goals, and approach, for which they hold themselves mutually responsible.

Treatment programmes are provided directly by a clinical interdisciplinary team led by the substance misuse clinician. This team comprises medical, nursing, other healthcare staff, together with addiction counselling and related clinical staff bound by common professional structures and ethical guidelines regarding the organisation and provision of treatment, respecting the right of the patient to confidentiality and appropriate clinical care.

The IPS seeks to provide clinical services for the assessment, treatment, and care of patients comparable to those available in the community, and which are appropriate to the prison setting.

Treatment programmes provided within the prison environment should be patient focussed, with the objectives of harm reduction, stabilisation of the patient's addiction, with a longer term aim of assisting the return of the patient to a drug free lifestyle.

All methadone treatment delivered in prison will be based on IPS Methadone Guidelines and/or other substitution guidelines depending on the agent used.

Advice in relation to the practical organisation of such treatment programmes is outlined in the IPS Healthcare Standards Manual (Standard 9).

2. ADDICTION TREATMENT CHARTER

It is the aim of the IPS to provide a high quality service to prisoners receiving treatment for addiction delivered with respect and courtesy upholding the dignity of all those involved. Each prisoner is central to his/her individual care plan. Care and treatment is crafted in a close collaboration between prisoner and health care worker in a therapeutic alliance.

A prisoner is entitled to:

- Access services regardless of age, race, gender, sexual orientation, religion, disability, marital status, family status or membership of the Travelling Community
- An assessment of individual need on presenting for treatment
- Access to appropriate treatment within an appropriate timeframe
- Information on all available prison treatment options
- Informed involvement in making decisions concerning treatment
- An individual care plan and participation in the development and review of the plan
- A respect for privacy and dignity from staff and other prisoners
- Confidentiality in relation to information given and an explanation of the circumstances in which information will be divulged to others
- An effective complaints procedure.
- Give or refuse consent to take part in clinical trials, research or the teaching of students
- A copy of this charter

A prisoner's responsibilities to the Addiction Service include:

- Respecting the privacy and dignity of other prisoners and of service staff
- Honouring commitments made in relation to their care plan or treatment contract
- Complying with organisational arrangements and any rules made by the IPS for the effective, efficient, and safe delivery of the service

Copies of this charter will be publicly displayed in healthcare facilities.

3. CLINICAL INTERDISCIPLINARY CARE PLANNING

Introduction

Treatment programmes are provided directly by a clinical interdisciplinary team led by the substance misuse clinician. This team comprises medical, nursing, other healthcare staff, together with addiction counselling and related clinical staff bound by common professional structures and ethical guidelines regarding the organisation and provision of treatment, respecting the right of the patient to confidentiality and appropriate clinical care.

Interdisciplinary care planning is seen as an opportunity to focus on coordination of patient care and to undertake regular reviews of professional practice. Collaborative work breaks down barriers, raising the awareness of each professional for the other. Interdisciplinary ownership of patient records improves the efficiency of recording information and communication between professionals. It allows care to be monitored and omissions to be spotted. There is more scope for care to be individualised. Patient satisfaction increases because of greater involvement in planned care. Other benefits include:

- Better communication within the team, allowing problems to be addressed more promptly
- Staff become more aware of their ongoing commitment to prescribing and evaluating care
- Professional satisfaction increases leading to higher staff morale
- Standards are met, professional carers are named and there are clear explanations of proposed treatments.

Policy

1. The IPS aspire that a care plan be drawn up for each patient receiving treatment for drug dependency.
2. Care plans should be realistic and patient-centred. All aspects of patient – biological, sociological, psychological and spiritual, should be considered in order to ensure holistic care.
3. The interdisciplinary team in consultation with the patient should draw up the care plan. Where appropriate the patient's family may be involved with the patient's consent.
4. Members of the interdisciplinary team, not familiar with care planning, should receive training.
5. Care plans should be reviewed as appropriate and review dates set and adhered to with a maximum of 6 months between reviews. It is advised that care-teams meet regularly to review goals and interventions.
6. The emphasis of the care plan and the main members of the core team may change as the patient progresses through treatment into rehabilitation.
7. Interdisciplinary or generic care plans are not a replacement for the required documentation from each discipline.
8. The interdisciplinary care plan is to be kept in the back of the medical chart and signed up at the care-team meetings by the person designated to make the required intervention.
9. If the required interventions are not made as per plan, the reason for this should be provided on the care plan, dated and signed.

Interventions should reflect the philosophy of care within the service.

4. METHADONE TREATMENT PROGRAMME GUIDELINES FOR THE IRISH PRISON SERVICE.

Based on European Methadone Guidelines

Summary

In most good programmes psychosocial interventions are considered a central part of methadone treatment. Research from the USA has demonstrated that there are several programme characteristics associated with treatment success such as comprehensive services and the integration of medical, psychosocial, counselling and administrative services (Ball & Ross, 1991). McLellan et al (1993) described that service users who receive counselling and other psychosocial services with their methadone had better outcomes than those who only received methadone.

The importance of creating and maintaining a therapeutic context in which methadone treatment programmes are delivered as part of the treatment of opioid dependence is widely accepted. As is the case with any other service user populations receiving any kind of treatment, individual methadone maintenance service users may vary in their needs and they may differ in their responses to components of treatment. The need for counselling and other interventions should therefore be assessed for each service user individually. Some service users need more assistance than others to get their lives in order. On the other hand, there is no reason why stable service users without major life problems should require counselling at all.

Service users with psychiatric disorders could benefit from psychotherapy. However, there is no reason to believe that psychotherapy is a treatment for all opioid dependants. ***Individual assessment is the key to good service delivery.***

Assessment of addiction and the degree of dependence is essential before prescribing methadone. Induction, treatment plan and initial dosage should all be determined with care. Service users need to be informed not only about the actual pharmacological effects of methadone and the dangers of using other substances when on methadone, but also about the potential risk of overdose.

It is highly recommended that new entrants start receiving methadone in the morning and preferably early in the week, so that the peak blood methadone concentrations occur when the health care area is still open and staff are available for consultation and intervention.

In general, the initial dose will be between 10 – 20mg. In cases where tolerance to opioids is high, the normal dose will be between 25 – 40mg. When tolerance is low or uncertain, a dose between 10-20mg is more appropriate. **If in doubt perhaps it is best to err on the side of caution and prescribe a lower dose**. While too much methadone can be fatal, insufficient methadone is unlikely to be effective.

During the first week of induction scheme, service user should be seen daily where possible so that a stabilisation dose can be established. Where doses need to be increased during this first week, the daily increase should be a maximum of 5 to 10mg and not exceeding 20mg within a week of the initial dose.

Careful consideration should be given if a dose increase exceeds 20mg per week. It can take up to six weeks or more to be properly stabilised on methadone treatment.

The majority of individuals in maintenance treatment will require 60 – 120mg per day. Although some individuals can be successfully maintained on lower doses, an average heroin dependent person will use less heroin and remain longer in treatment, if maintained on higher rather than lower doses of methadone.

Some groups such as pregnant women, people with HIV disease, service users with young children etc (see emergency criteria for treatment), should be given priority to enter methadone treatment. They may also need special attention. Liaison should be co-ordinated with specific services as antenatal, infectious diseases, so that their immediate problems can be addressed.

Methadone treatment should not be seen as an isolated intervention but as part of a comprehensive programme of care. It is important to identify and address other problems such as medical, social, mental health or legal problems. This can be done either by the staff within the methadone programme or through liaison with other services and institutions. A multidisciplinary approach to methadone treatment is essential.

Prescribing is the sole responsibility of the doctor who signs the prescription. This responsibility cannot be delegated.

Apart from methadone, a range of other substitution medication is prescribed in different countries with success, such as Buprenorphine, long acting morphine and heroin.

People working in methadone treatment will require specific training which addresses the pharmacological, toxicological, medical and psychosocial aspects of treatment of opioid dependence. The attitude of the staff needs to be non-judgemental. Supervision and regular team meetings are important elements of good practice. To ensure high quality of the services delivered, continuous training is highly recommended.

Keeping records of prescribing and of any activity surrounding a service user is necessary as in any medical practice, this may be computerised, hand written and combination of both. A central list of service users in methadone treatment may prevent double prescribing. The information contained on this is confidential and access to the list is restricted to doctors and clinical team who provide the treatment.

A methadone treatment programme should be a safe place. It should be easily accessible centrally located and clean. At all times, service users should be assured of the confidentiality of their information and that it will not be used for non-medical purposes (see policies regarding confidentiality). A good rapport between the staff and the service user is vital for the success of the treatment.

When planning and designing a new treatment service, it is important to involve users of this service in the process as well were possible.

Monitoring activities and evaluation of outcomes should be undertaken on a regular basis.

Chapter 1: Introduction

Of critical importance is the recognition that, as in every other area of medicine, treatment must be tailored to the needs of the individual service user.

These guidelines are not intended to dictate, but rather provide guidance and recommendations for good clinical practice of methadone treatment programmes.

Methadone Substitution Treatment in Europe

The type of methadone programmes varies from low threshold programmes in some countries to high threshold ones in others. Both high and low threshold are formed in the Irish Prison Service.

Low threshold programmes:

- Are easy to enter
- Harm reduction oriented
- Have as primary goal to relieve withdrawal symptoms and craving and improve the quality of life of service users
- Offer a range of treatment options

High threshold programme

- Are more difficult to enter / may have selective intake criteria
- Abstinence oriented (including methadone abstinence)
- Have no flexible treatment options
- Adopt regular (urine) controls
- Inflexible discharge policy (illegal opioid use not consented)
- Compulsory counselling and psychotherapy

Most countries have seen a rapid expansion in the provision of substitution services, especially in Spain, France, and Greece and in some Central and Eastern European countries. A rapid expansion is even more evident in countries like Luxembourg, Finland and Greece, which had lower baseline levels of provision. The impetus for the expansion has largely been a response to the HIV disease epidemic among drug users. Whilst most countries have experienced few problems during this growth period, concern has been expressed in some member states. It concerned the lack of training and skills of some practitioners who are now involved in substitute prescribing. This is particularly notable among specialist services, including general practitioners and pharmacists (Department of Health UK guidelines, 1999; Farrell et al., 1999). There is also concern about controls on prescribing and the risk of possible diversion of methadone onto the black market (Farrell et al., 1999).

Chapter 2: The evidence for the effectiveness of methadone

Pharmacology

Methadone (*methadone hydrochloride,* or 6-dimethylamino-4, 4-dipheny1-3-hepatone hydrochloride) is a synthetic opioid agonist that has effect on humans similar to those observed with morphine. Methadone is well absorbed from the gastro-intestinal tract, irrespective of formulation type (e.g. syrup vs. tablet). It has very good bioavailability of 80 to 95%. The elimination half-life of methadone has been estimated to be 24 to 36 hours, with considerable variation across individuals (10 to 80 hours).

The rate of metabolism of methadone by the CYP3A4 enzyme affects the clearance of methadone from the body. The expression of the CYP enzyme is influenced by genetic and environmental factors and by certain medications. It is highly variable which can result in methadone toxicity and at the other extreme, in opioid withdrawal. Certain medications interact with the blood level concentration of methadone and special attention has to be given to people using other medications such as HIV medications, antibiotics, some anti-epileptics and medications that treat tuberculosis. For more information on the interaction of methadone and other medications we refer to appendix 14 of the UK Guidelines and to the Methadone Briefing by Andrew Preston, 1996. The UK Guidelines can be consulted on the Internet: http://www.doh.gov.uk/drugdep. The Drug Misuse and Dependence-Guidelines on Clinical Management.

Side effects of methadone occur in the neuro-vegetative and psychological area. The most common side effects include: increased transpiration, constipation, and disturbances of sleep, sex drive and concentration. Such undesirable side effects may persist over longer periods of treatment, but mostly remain without medical consequences. In total, these side effects affect less than 20% of methadone service users (Swiss Methadone Report, 1996).

Methadone treatment with full tolerance and stable doses does not usually impair the ability to drive or operate mechanical machinery. All service users that are not stable are strongly advised not to drive or operate mechanical machinery, and should be informed that if deemed at risk to others, confidentiality may be broken. Where service users are being prescribed further psychotropic medication, further consideration to their ability to drive or operate mechanical machinery should be questioned. However, before issuing or reissuing a driver's license, careful checking is advisable to determine whether the service user's situation is stable; whether there are any chances of relapse, and whether there is consumption or misuse of other substances. Especially the simultaneous use of alcohol and/or medications (e.g. benzodiazepines) should be taken into consideration (Swiss Methadone Report, 1996).

Research

Most research on methadone has been done in the USA. The National Institute on Drug Addiction (NIDA) has funded and co-ordinated several studies which have examined various treatment outcomes of methadone maintenance treatment in the United States. Some of these research projects were: the Drug Abuse Reporting Programme (DARP) studies with a 12-year follow-up; The Treatment Outcome Perspective Study. (TOPS) gathered data before, during and after treatment on a nation-wide scale and The Methadone Research Project (The Ball and Ross Studies) looked at the effectiveness and status of MMT in six programmes in three cities (International Forum, 1994).
Opiate addiction is complicated and that has both metabolic and psychological components. It is important to deal with both aspects of this condition. Since it is a condition where a service user is prone to relapse, careful risk assessment of this possibility should preclude any decision to stop methadone prescribing.

Another important study is the British follow-up study of the National Treatment Outcome Research Study (NTORS), which monitored the progress of 1075 service users in residential and/or community treatment services over five years (Gossip *et al.,* 1998).

In conclusion, research supports the conclusion that methadone maintenance is more effective than no treatment or placebo in retaining people in treatment, reducing use of Heroin and other illicit drugs, preventing HIV infection, improving the health –related quality of life, and reducing involvement in criminal activity and imprisonment rates. Detoxification alone is seldom effective in producing long-term change. The benefits of methadone maintenance programmes can be maximised by retaining service users in treatment, prescribing higher rather than lower dosages of methadone, orientating programmes towards maintenance rather than abstinence, offering counselling, assessment and treatment of psychiatric co-morbidity and social treatments and the use of contracts and counselling to reduce the use of additional drugs (Preston, 1996; Farrell, 1994; Ward, 1998).

Chapter Three: Outline of Best Clinical Practice

Criteria for Treatment

There are two internationally accepted diagnostic criteria that cover drug dependence: the first criteria of ICD 10 which defines Dependency syndrome as: *"A cluster of physiological, behavioural and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had a greater value………*"(WHO Expert Committee on Drug Dependence, 1998).

Substance dependency is diagnosed if at least three of the following criteria had been present in the previous year:

Psychological:

- Strong desire or compulsion to take the substances
- Difficulty in controlling behaviour regarding the onset, termination or levels of use

Physiological:

- Characteristic withdrawing syndrome or the substance if not taken
- Evidence of tolerance and need of increased dose to achieve effect

Social:

- Progressive neglect of alternative interests/pleasures and increased time necessary to obtain, take or recover from substance
- Persisting with substance use despite the negative harmful consequences

The criteria for entering methadone treatment differ widely between programmes.

High threshold programmes adopt strict criteria, such as:

- A minimum age of 18 (under in some cases)
- History of failed treatment attempts
- Strong motivation to enter treatment
- One of the international diagnostic criteria for opioid dependence

Some methadone programmes only accept heroin addicts for treatment if they suffer from illnesses, such as HIV disease or tuberculosis.

At the other end of the scale there are low-threshold programmes, which would welcome anybody with a proven addiction to opioid who wish to enter a treatment programme.

The criteria differ according to the type of treatment (maintenance or detoxification) because of the length of time a service user is expected to be in treatment. Other factors, such as the availability of places, may influence inclusion criteria. In areas where there are no waiting lists, programmes can adopt looser criteria than in places where there is a larger demand than supply of treatment possibilities.

Assessment

It is recommended best practice that all service users receive an initial nursing, counselling and doctors assessment before starting treatment. Before starting any type of methadone treatment it is necessary to determine whether the service user is taking opioids and to establish the presence and severity of opiate dependence**. The doctor should conduct a personal interview with the service user and carry out a physical and mental state examination and have available the results of recent urine toxicology.** The final decision for the type of treatment should be taken on the basis of the needs of the individual service user and the options open to the clinician. To ensure a successful treatment programme, the clinician or assessor is required to give the service user information on the full range of treatment options. It should be ensured that the service user is matched to the most appropriate treatment for their current needs. Further, when starting methadone or psychoactive substances, the doctor should give to the client detailed information on the treatment, on the possible side effects of the medication and the potential social consequences (such as long-term dependency and increased tolerance).

Part of the assessment process for new committals must include a minimum of one urine with specific test for heroin metabolites (6 A. Morph). The doctor before their initial assessment of the service user should review nursing and counselling assessments.

Urinalysis can be helpful in confirming opioid use, however, this should be considered with care. It may encourage the use of opioids prior to an assessment. Furthermore, it can only confirm opioid use, but it does not provide any information about the extent of use or dependence. Its main usefulness may be in determining the use of other substances presently being used by the applicant (Ward et *al.,* 1998). The results of any urinalysis should be considered only with a thorough clinical examination.

Treatment plan and treatment goal (duration and dosage)

Although these guidelines cannot modify potential local restrictions in therapeutic options, it can be stressed that the international literature, as well as the experience overtime in different parts of the world, underline the importance of the availability of a room for individual treatment assessment. Restrictions in availability of places, in dosages and duration or type of treatment are counter-productive in the effective treatment of opioid dependent service users. Making decisions about the treatment of individual service users has to be based as much as possible on a thorough assessment of what will work for that person and on reliable information about what works (Preston, 1996). The decision about what treatment to offer is based on what treatment is available locally, on the service user's previous history, current situation, social support network and expressed wishes. The decision is also based on the clinician's judgement of the required degree of structure, monitoring and support of the service users needs.

Opioid use and dependence is associated with a range of medical, legal and psychosocial problems. Additional problems should be addressed from the very beginning, either by the methadone programme itself or through referral to an appropriate service.

Induction

The calculation of the right starting dose should take the following factors into account:

- That the right dose varies according to the treatment aim;
- That illicit heroin varies in purity from area to area and from time to time;
- That methadone is a long acting opiate;
- That too much methadone can be fatal but insufficient methadone is unlikely to be effective.

Starting service users on a dose of methadone that is too high may result in toxicity and death. However, there is some danger inherent in the administration of a dose of methadone that is too low, in that withdrawal may occur. The experience of withdrawal symptoms may prompt service users to seek relief from other sources, such as illicit opiates and benzodiazepines. The combination of methadone with other substances may result in toxicity and death. Furthermore, some service users may metabolise methadone quite rapidly and may also be in danger of withdrawal and self- medication (Humeniuk *et al.,* 2000). There is evidence that people entering treatment have a higher risk of dying during the first month than before they entered treatment (Caplehorn, 1999).

Once opioid dependence has been confirmed in a service user, tolerance and methadone dose need to be assessed. The usual way to determine tolerance is by clinical assessment of the service user's medical and drug use history upon presentation. Accuracy of clinical assessment may be improved by using corroborating evidence such as examining veins for evidence of injecting opioid use or urine tests. A good rapport with the service user is vital in obtaining the necessary information. It is important that enough time is allocated for the clinical interview as well as communication with other practitioners whom service users may have seen.

The absolute condition for an effective start of methadone treatment is to provide the service user with relevant information, which should include the following:

- The delay of 2 to 4 hours before methadone has a peak effect;
- The accumulation of methadone over time resulting in a greater effect over 3 to 5 days or more, even on a fixed dose;
- The risk of poly-drug use while on methadone, particularly other opiates, cocaine, benzodiazepines and alcohol;
- The effect of medications that induce or inhibit activity on subsequent methadone concentrations. (for more information we refer to appendix 2).

One more of the following criteria can identify service users with a higher risk of methadone toxicity:

- It is their first presentation to that practitioner and their medical and drug use history is unclear;
- They are at high risk of poly-drug use of dependence
- Their degree of neuro-adaptation is uncertain
- There is risk of overdose on methadone or any other drug
- They have a clinically significant respiratory disease
- They have clinical evidence of the end stage of liver disease
- They are currently being administered drugs that inhibit the CYP3A4 enzyme (*).

Clinical titration of dosage needs to keep in mind the possibility of liver disease.

It is highly recommended that methadone is commenced in the morning and preferably early in the week, so that the peak blood methadone concentrations occur when health care area is open and fully staffed enabling staff to intervene. It is not recommended to start a new service user immediately before a holiday period.
The aim of induction is to eliminate withdrawal.

In general, the initial dose will be between 10 – 20mg. In cases where tolerance to opioids is high, the normal dose will be between 25 – 40mg. When tolerance is low or uncertain, a dose between 10-20mg is more appropriate. **If in doubt perhaps it is best to err on the side of caution and prescribe a lower dose**. While too much methadone can be fatal, insufficient methadone is unlikely to be effective.

During the first week of induction scheme, service user should be seen daily where possible so that a stabilisation dose can be established. Where doses need to be increased during this first week, the daily increase should be a maximum of 5 to 10mg and not exceeding 20mg within a week of the initial dose.

Careful consideration should be given if a dose increase exceeds 20mg per week. It can take up to six weeks or more to be properly stabilised on methadone treatment. Compliance will only be maintained if both service user and doctor agree that a reduction scheme is desirable.

The majority of individuals in maintenance treatment will treatment will require 60 – 120mg per day. Although some individuals can be successfully maintained on lower doses, an average heroin dependent person will use less heroin and remain longer in treatment, if maintained on higher rather than lower doses of methadone.

Detox regime suggestions

The present policy in the IPS is to detox clients with a proven drug history *unless they fall into the following categories.*

- Currently on methadone maintenance.
- HIV positive.
- Pregnancy.

Assessment Process

On committal to the institution the individual must be assessed by the nurse, if there is a history drug use, particularly if the person has not been treated with methadone before.

A urine must be taken for toxicology specifically testing for heroin metabolites (**6 Acetyl- Morph**), the results of which must be available to the doctor examining the person prior to prescribing methadone.

- **The day of committal the person will not receive methadone (Day 1).**
- **Day 2. - The individual will be seen by the doctor with the results of the test.**
  A maximum of 20 mgs Methadone to be dispensed.
- **Day 3. – Reassessed by the doctor and dose titrated based on clinical findings.**

  Extreme caution to be used in concurrent prescribing of benzodiazepines and other psychotropic drugs.
  Caution should also be exercised when assessing the 16 – 19 y.o.

During this induction period the person should be kept under regular nursing and medical observation.

Many service users, despite requesting detoxification, are more suitable for maintenance treatment. Options should be sensitively explored with the service user, and the overall goal should be to maximise the service users potential health gain.

Undertaking a regular clinical review will ensure that the potential goal of abstinence can always be reconsidered. Yearly case plan review is strongly recommended for all service users.

TREATMENT

Maintenance programme suggestions

Research suggests that the majority of individuals require 60-120mg per day. Although some individuals can be successfully maintained on lower doses, an average heroin dependant person will use less heroin and stay in treatment longer, if maintained on higher rather than lower doses of methadone. In situations where high daily doses fail to prevent withdrawal during the full 24 dosing cycle, it should be determined if the individual is taking enzyme-inducing drugs concurrently, or if the individual metabolises methadone at a faster rate than average and higher methadone doses will be needed (Humenuik *et al*, 2000; Preston, 1996; Ward *et al*, 1998). Methadone levels should be performed on any service user receiving more that 100mgs.

Although the majority of service users can be adequately treated with a daily dosage of between 60-120mg there are no objective data (include methadone plasma concentration) to suggest an adequate daily dose for an individual service user. Asking the service user's opinion about methadone dosage can have a positive effect on the treatment.

Caution needs to be observed about high doses if there is associated alcohol/ Benzodiazepine dependence that could be the result of an under-medication with methadone. In this case the stabilisation dosage needs to be reconsidered (Maremmani & Shinderman, 2000)

In the prison setting when an established methadone maintenance patient is committed the following procedure should be followed.

- **Verify with the Central Treatment List (CTL) where the patient is registered as receiving his/her methadone.**
- **Having verified where the patient is attending, contact should be established to ascertain the current dose of methadone, when it was last administered and any other relevant medical information.**
- **This information should be furnished to the doctor and continuation of his/her prescription should ensue as appropriate.**
- **Urine should be screened for methadone and other illicit drugs.**

Initially, service users may need to be seen by the doctor weekly and if stable fortnightly and then monthly. A more thorough review may be useful every three months to consider what has been achieved and to set new goals. **Twice weekly urines are recommended in the initial stages and thereafter weekly**. Co-existing physical, social, psychiatric and legal problems should be addressed as much as possible.

Detoxification from Methadone Maintenance Treatment

The available research suggests that the slower the course of diminishing doses, the better. However, like all other decisions regarding the treatment plan, this can best be set individually in consultation with the service user. Supportive counselling is also considered an important part of withdrawing for maintenance and this should be continued after service users have finished the reduction regime because of the post-methadone syndrome. This syndrome is associated with mild symptoms of the protracted withdrawal phase as well as with issues related to leading an opioid-free life. The development of aftercare services in some places is an answer to these problems and involve a mix of education, skills training and features derived from self-help groups like Narcotics Anonymous (Ward *etal;* 1998).

Systematic Detoxification on Committal

At present any person giving a history of opiate use and testing positive for opioids on committal will be offered a medically assisted symptomatic detoxification for operational reasons. A patient can present to healthcare staff for further assessment of other treatment option which may include methadone maintenance subject to the availability of a community place.

Populations requiring special consideration

Pregnant Women

Attracting and maintaining pregnant women in treatment services is vital. Where possible the partner should be taken on as well. It is advisable to give pregnant women priority to enter Methadone treatment because of the health risks for both the mother and the foetus associated with substance abuse, such as premature labour. Multiple drug use, poor nutrition and unsafe injecting can damage the foetus. The long term outcome of women who enter methadone treatment programmes during pregnancy is better in terms of their pregnancy, childbirth and infant development, irrespective of continuing illicit drug use. Women attending treatment services usually have better antenatal care and better general health than drug-using women not in treatment, even if they are still using illicit drugs (Finnegan, 2000)

Once a stable treatment programme has been established, liaison with other medical services, particularly for antenatal care, can be initiated. This can be facilitated particularly through the Drug Liaison Midwife.

Although many women would wish to detox, long-term methadone maintenance treatment is considered the best option for most opioid dependant pregnant women. In the third trimester, many women will need higher doses because of weight gain and other physiological changes.

If a woman wants to detoxify, it is recommended not to do this in the period prior to week 12 or after week 32 of pregnancy (Council of Europe, 2000). Withdrawal symptoms should be avoided but particularly during the first trimester of pregnancy because of the risk of premature labour in this period. The normal maximum reduction in the daily dose is between 1 –5mg weekly, fortnightly or monthly, depending on the woman's response. Women should not be encouraged to detox in the final trimester of pregnancy.

If detoxification is unsuccessful and the service users drug use becomes uncontrolled, methadone dosage should be re-assessed until stability is regained.

Neonates of Opioid Dependant Women

Over 60% of neonates born to opioid dependant mothers have symptoms of neonatal abstinence syndrome (NAS) that tend to occur 24-74 hours after delivery and include the following: high-pitched cry, rapid breathing, hungry but ineffective sucking and excessive wakefulness. Hypertonicity and convulsions can also occur. The intensity of the NAS does not directly correlate with the dose of the methadone or other opioids used by pregnant women. The use of Benzodiazepines by the mother in the anti-natal period and diarrhoea in the neo-nate can considerably prolong the period of withdrawal and may result in respiratory depression.

They can usually be cared for in a normal maternity environment on condition that in case of emergency, they could be transferred to special care units.

If medication is required, a range of opioid and non-opioid drugs can be used. An oral morphine concentrate is the drug of choice and phenobarbitone may be used if the mother had been taking other substances, such as benzodiazepines.
Breast feeding is encouraged not only because of its general advantages but also because some methadone may pass to the baby in very low doses and this in turn may help to reduce any withdrawal symptoms of the baby. In case of HCV infection, the benefits of breast-feeding should be considered according to the mother's viral load (Council of Europe, 2000). Contra-indications for breast-feeding however are: if the mother has HIV disease or if she uses high doses of Benzodiazepines or if she continues illicit drug consumption.

Finally, because pregnant women and young mothers may suffer from severe guilt feelings, psychosocial care and counselling is highly recommended.

Parents of young children

Drug use is not a reason to introduce care proceedings. The needs of young children of drug dependant parents are, however, paramount. Workers in methadone programmes will need to include the care of the children in their treatment plan and have some means of supervision. There are special programmes co-ordinating the care of the parents and young children, case management of these service users is a key issue and the specific needs of the children should be considered explicitly (Children First Department of Health & Children – September 1999)

Young People

Methadone is unlikely to be an appropriate treatment for people under 16 years of ages as they are unlikely to fit the criteria of:

- Long term opioid use
- Significant tolerance
- Level of problematic opioid use which would not be possible to treat with another form of treatment and help.

If methadone treatment was nevertheless considered, specialist assessment and management is advised. Parental consent is required. In very rare circumstances treatment may be initiated after multidisciplinary/specialist review and legal opinion.

People with HIV Disease

It is strongly recommended that all people in treatment should be tested for Hepatitis B and those without protective antibodies, should be vaccinated (See Vaccination Schedule – ERHA Publication March 2001).

Hepatitis C is a serious health problem for injecting drug users, both in terms of prevalence and its clinical effects. There is a great need for improved methods of diagnosis and management of people with hepatitis C. The dose of methadone will have to be reviewed and analysed, according to the liver function of the service user. Specialist referral should be arranged for assessment and possible treatment of HCV. People who are stable on methadone can be very compliant with HCV treatment. Finally, as is in the case of people with HIV, it is important to reiterate the avoidance of sharing injecting equipment.

People with mental health problems

A significant percentage of opioid users may suffer from mental health problems, including anxiety and depression. A percentage of opioid users presenting at services have suicidal and self-harm risk. Entry into treatment has a significant positive impact on their psychological well being. A minority (circa 10%) have severe enduring mental health problems that require close collaboration with mental health services (Marsden, et al., 2000).

Dually diagnosed opioid dependant service users who survive early attrition, tend to stay in treatment longer than those without psychiatric co-morbidity do, when treated with higher methadone doses during the stabilisation phase (Maremmani et al, 2000).

Poly Drug Users

In order to deal with additional substance misuse, the health worker must be aware of other poly substance misuse including alcohol and benzodiazepines, so appropriate intervention can be made. It is vital to establish a good therapeutic relationship if these issues are to be addressed. A good rapport based on trust and co-operation between prescriber and service user makes for good treatment.

Strategies to reduce risk behaviour include: increasing the methadone dose and possibly other medication, the frequency of collection, supervised consumption, setting realistic treatment goals and finally, in some programmes, the suspension of methadone prescribing.

Minority ethnic groups

In many areas, opioid dependence can be a problem among ethnic minorities. Often, services are developed for and run by people from the mainstream population and culture. In order to make services more attractive to ethnic minorities, it is important to offer culturally appropriate services.

People in prison

People in prison should have the same access to the same treatment options as in a community setting. In 1998, the Prison & Drugs Conference in Oldenburg, presented recommendations for drug services in a prison setting. They recommended that a wide range of drug services should be available to prisoners, including substitution

treatment (both detoxification and maintenance). It was also recommended that prison staff needed to be trained on drugs and related (health) problems.

Individuals on maintenance in the community should have the option to continue to be maintained upon entry to prison. This option is important since discontinuing methadone maintenance treatment is likely to result in higher levels of risk behaviour (Swiss Methadone Report, 1996).

People receiving substitution treatment in prison must be able to continue such treatment on release. There is particularly high risk of overdose and death after release if service users have been abstinent from opioids (Darke et al, 1996). Decisions on continuity should be taken in consultation with the treatment programme in which the prisoner participates once outside prison (European Recommendations, 1998), direct liaison arrangements are important in this regard.

People in hospital

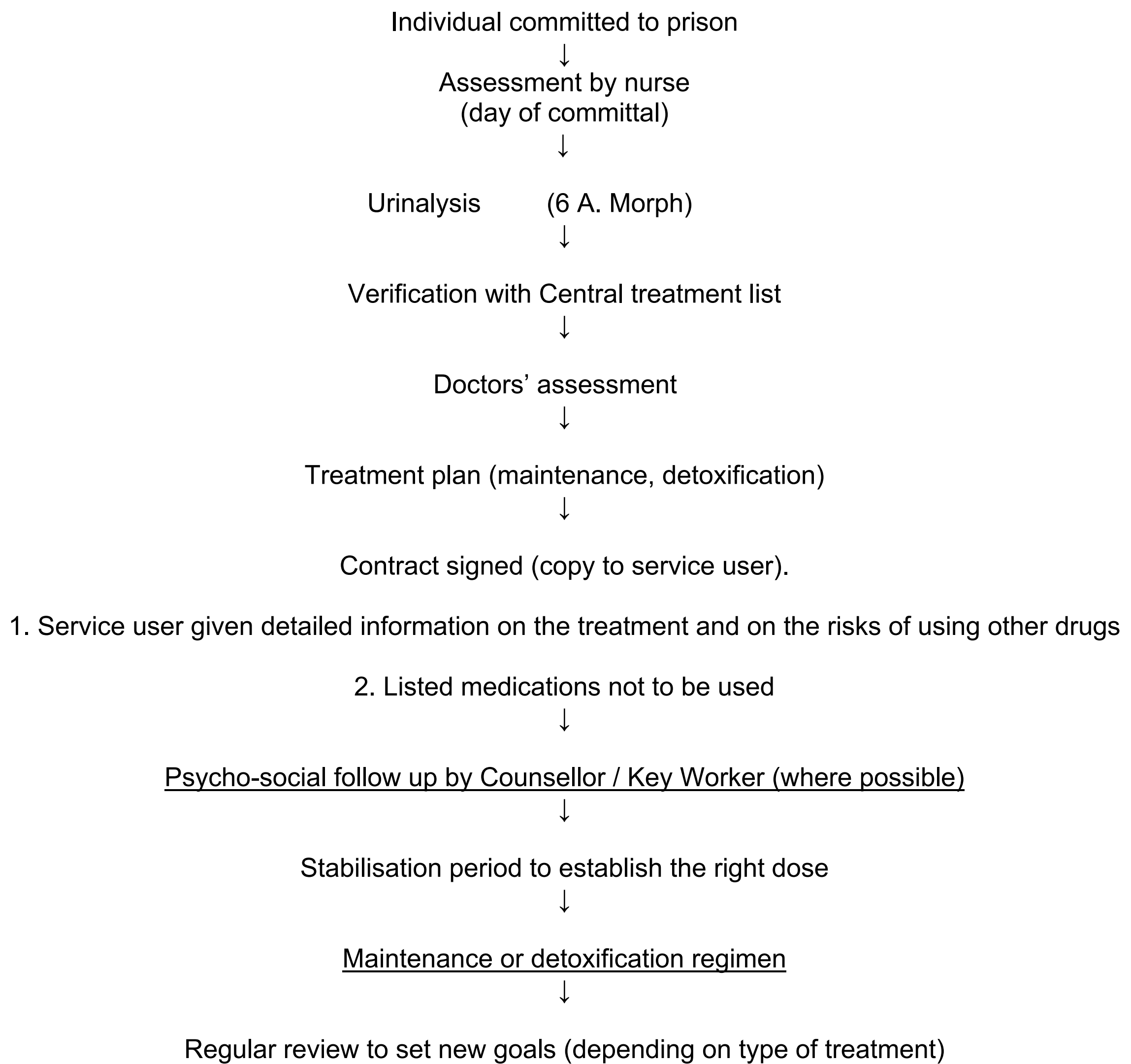
It is important that general hospitals recognise and treat service user with opioid dependence. After proper assessment and communication with the drug treatment service, service users should be able to continue their methadone medication and all other medications in such a way as to ensure the completion of the medical treatment for which the service user entered the hospital. It is worth noting that general hospitals should not be considered as detox centres. The drug treatment offered in hospital should allow for full treatment of the medical problem.

The emergency department of a hospital will mainly encounter two situations:

- The management of severe abstinence and or overdose;
- The management of other drug related problems.

Liaison between drug services, prison drug services and emergency departments are essential and joint policies between the two departments should be developed at local level.

Steps in Methadone Treatment



Chapter 4: Psychological and Social Aspects of Care

European Guidelines regarding the provision of Methadone programmes clearly state that Methadone treatment as a pharmacological intervention should not be an isolated activity but rather part of a comprehensive programme of care addressing the following elements –

Multi-disciplinary assessment at the earliest stage.
Development of through care plans and regular multi-disciplinary review of these.
Provision of appropriate services to address the myriad of needs experienced by drug misusers.
Programmes must have an active re-integration focus.

Indeed meta-analytical studies demonstrate that Methadone programmes, which are shown to be the optimum treatment choice for opiate misuse, are the Methadone programmes which clearly incorporate adequate Psychological and Social components.

The provision of Methadone programmes has implications for the positive sentence management of those on methadone, but also for the initial targeting of resources for the provision of comprehensive psycho-social interventions. There is a recognized need for the development of appropriate psycho-social interventions in line with best community and international practice.

Critical Factors

The development of Psychological/Social interventions in relation to Methadone programmes within prison requires attention to the following factors –

Adoption of a care planning/ case management approach.

This factor is well attested to in all literature concerning drug treatment initiatives in prison or the community. Such an approach might well integrate with the concept of positive sentence management envisaged by the strategy statements of the Irish Prison service. The adoption of a case management approach by definition, indicates that assessment and intervention should be broad based and multi disciplinary. Consequently the provision of a Methadone programme should involve best medical and psycho social practice and allied supports.

The National Institute of Drug Abuse (NIDA) model of practice is a useful template upon which to construct methadone programmes.(Figure 1.overleaf) This model clearly locates the provision of pharmacotherapy such as Methadone, within a wider treatment and environmental context.

Dale & Marsh (2000) emphasise the crucial importance of effective care planning and case management, as purely focusing on substance use related issues is rarely sufficient to produce enduring change.

Counselling can effectively complement methadone programmes, however the research evidence points to the need for a more comprehensive approach to methadone programmes than the provision of methadone alone. Appropriate methadone programmes within a prison (and affirmed by community treatment centres), due to the multiple problems experienced by those in prison, require the adoption of a case management approach where there is assessment of and intervention for the myriad of problems faced by the individual such as accommodation, dual diagnosis, offending behaviour and family issues. The provision of methadone programmes within prison should be viewed in the context of reintegration.

<u>Guiding Principles</u>

- **The provision of a keyworker for every person commencing a Methadone programme.**
- **A (through) care plan should be developed for each individual with built in regular review (as per National Drug treatment strategy)**
- **Plans and services to be tailored to the individual needs of the person.**
- **Drug treatment care plans must integrate with Positive sentence management approaches.**

Pre/ Post- Release / (Re) Integration Issues

The NIDA model (Figure 1.) Clearly demonstrates the importance of social factors in the ability of a person to maintain the stability that might be afforded to them from participation in a Methadone programme, and any other

changes in lifestyle they may have attempted or are intending to make on release from prison. The ability to access or make linkages with a variety of relevant social services in the community is a critical factor to the person in making a successful transition to the community from prison. Methadone programmes must incorporate these considerations in the range of interventions offered and the skill mix of those offering them. Planning for those on Methadone programmes in relation to release/(re) integration will require the appropriate and coordinated involvement of statutory and voluntary agencies

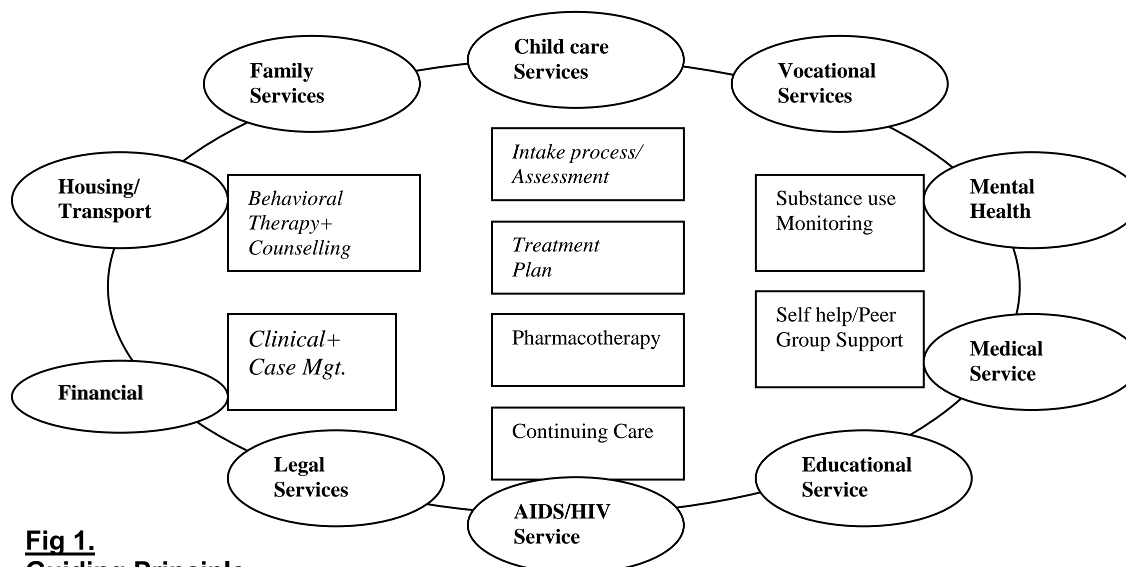


Fig 1.

Guiding Principle

- **Through care plans should have an active (re) integration focus**

The creation of a therapeutic and supportive environment within the prison

A critical success factor for the provision of any prison-based treatment programmes is the promotion of a programme-supportive environment. Attention must be paid to the physical, psychological, and social environment of a prison and the conditions prevailing in prison which are so different to those in the outside world. In addition significant preparatory work is needed to achieve the support and active collaboration of prison management and staff for any proposed programmes (Murphy 1998). There must be access to quality social and institutional supports, including non-drug using networks for those participating in methadone programmes. It is also critical that prison –based programmes are structurally linked with community –based interventions. In the absence of this gains made in prison will not be maintained in the community.

Drug dependence is not necessarily an idiographic, psychological deficit and treatment should be tailored not only to individual needs, but also mapped onto the context in which the individual finds him or herself

It should be noted that those people entering prison with substance misuse problems are likely to be multi-problem individuals with a host of serious problems which will not remit or moderate even if stabilisation is achieved in relation to their current substance misuse. McKay & McLellan state (1998) that there is a strong argument for combining substance treatment with a broader array of services ("one-stop shopping") where a more multidisciplinary approach can be taken to poly problem individuals.

Guiding Principles

- **The creation and maintenance of a supportive treatment environment, where staff and participant efforts are understood and valued by all.**
- **The need for appropriate adaptations to the physical environment, reflecting lower and higher threshold programmes. E.g. Kitchen/Communal dining opportunities for people on high threshold programmes. Multi purpose space for the provision of various types of programmes**

Use of evidence- based practice

The National Drugs Strategy 2001-2008 (Government Publications,2001) , states that there is a need to consolidate and further develop treatment approaches, which are proven to be effective and which are based on international evidence-based responses to substance misuse.

The majority of drug misusing clients in prisons have multiple issues which can combine to create a complex case. Accordingly a clearly developed care plan, based on a broad based assessment model, should form the basis of all interventions. Effective components of care planning with those on a methadone programme are: goal setting, motivational interviewing, problem solving and relapse prevention and management interventions.

These interventions must however be offered in the context of the stepped care literature and consider the needs of the individual or population of individuals receiving the service, in order to integrate client factors into the process.

Stepped care, based on the interaction between stage of recovery, individual needs and intervention, plays a critical role in the effectiveness of appropriate therapies. It is also essential to the development of services, within a prison context, as those in receipt of Methadone programmes are a very heterogenous group with widely differing needs and management issues.

The National Institute on Drug Abuse (2000) has presented a summary of the evidence base of treatment effectiveness in this area, in the form of 13 general principles. (Fig 3)

Guiding Principles

- **Adoption of a stepped care approach in recognition of the heterogeneity of the population on Methadone programmes**
- **Use of evidence –based responses**
- **Develop a variety of programmes for those in receipt of Methadone detoxification , maintenance and reduction interventions e.g. Pre-entry programmes, motivational programmes, higher threshold programme**

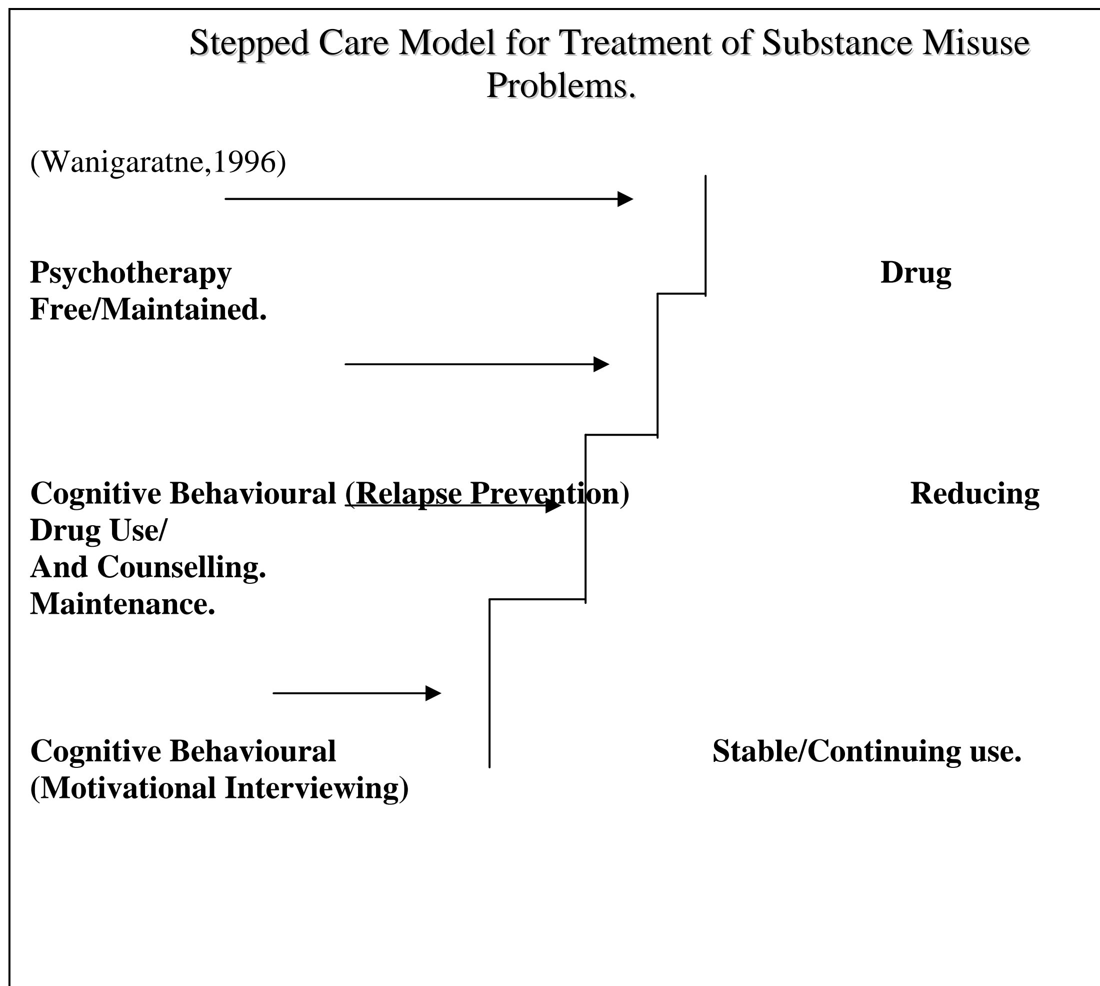


Figure 2.

Given the increasing provision of methadone programmes within Irish prisons, which is compatible with community practice, there is a need to locate the provision of Methadone within programmes that have appropriately developed psycho-social interventions.

1. *No single treatment is appropriate for all individuals.*

2. *Treatment needs to be readily available.*

3. *Effective treatment attends to multiple needs of individual, not just his/her drug use.*

4. *An Individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the needs.*

5. *Remaining in treatment for an adequate period of time is critical for the treatment effectiveness.*

6. *Counselling (individual and/or group)and other behavioural therapies are critical components of effective treatment of addiction.*

7. *Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies.*

8. *Addicted or drug abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way.*

9. *Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.*

10. *Treatment does not need to be voluntary to be effective.*

11. *Possible drug use during treatment should be monitored continuously.*

12. *Treatment programmes should be provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counselling to help patients modify or change behaviours that place themselves or others at risk of infection.*

13. *Recovery from drug addiction can be a long- term process and frequently requires multiple episodes of treatment.*

Fig.3 NIDA (2000)

Chapter 5

Practical issues of programme organisation

Methadone treatment services are organised in a variety of ways throughout Europe. Sometimes, local legislation only allows specialised centres to prescribe methadone while in other places general practitioners and community pharmacies are involved. One argument at hand is whether methadone treatment is considered a specialised service or part of primary care. This depends on local legislation and on the way health care is organised in a given area.

When a treatment system is developed in any country, it should be planned as an integral part of the community's overall resources to deal with health and social problems. It should be 'population-based' (WHO Expert Committee on Drug Dependence, 1998).

The following section focuses on the elements that are vital in organising best practice of methadone treatment. The elements discussed include staff requirements, the role of other services and the physical setting of programmes.

Staff requirements

There is a considerable variation across countries as to who can prescribe methadone medication for the treatment of drug dependence. Nevertheless, it always involves a medical doctor, be it a specialist, general practitioner or psychiatrist.

Training

It goes without saying that a medical doctor needs to be knowledgeable about specific issues related to opioid dependence in order to be an effective clinician. Training programmes are essential so that the doctor is equipped to carry out good clinical practice. Whether these training programmes are organised as part of the general training of doctors or only given to those who start working in the drug field remains open and dependent on the local situation. Obviously, the best practice would be a combination of the two. Medical schools should include drug dependence and the different forms of treatment in their curriculum. A specialised training programme should also be available to doctors who are about to start working in the field of drug dependence and methadone treatment (See ICGP Guidelines).

Drug Treatment forms part of the induction training for nurses entering the prison service.

Training possibilities are equally important for all other staff involved in the treatment of opioid dependence. The content of these courses should include the pharmacological, toxicological, and clinical as well as psychosocial aspects of opioid dependence. Regular seminars, supervision, and communication with colleagues always form an essential part in keeping abreast of current developments in any field of medicine.

Team work

Medical practitioners should not prescribe methadone in isolation. A multidisciplinary approach to drug treatment is essential. This team work should reflect the interrelated medical, psychological and social aspects of an appropriately structured methadone programmes.

Role of the medical doctor

A doctor prescribing controlled drugs including methadone for the management of drug dependence should have an understanding of the basic pharmacology, toxicology and clinical indications for the use of the drug, dose regime and therapeutic monitoring strategy if they are to prescribe responsibly.

Irrespective of the composition of the staff of a methadone treatment programme, prescribing is the sole responsibility of the doctor signing the prescription. The responsibility cannot be delegated.

It is the clinicians' responsibility to make sure that the service user receives the correct dose and that efforts are taken to ensure that the drug is used appropriately and not diverted onto the illegal market. Particular care must be taken with induction, especially in case of self-reporting dosage.
Clinical reviews of service users should be undertaken regularly.

Role of the nurse

As part of a multidisciplinary team the nurse provides a standard of nursing care to service users in a primary health care setting conforming to best practice, An Bord Altranais code of professional conduct.

In addition to carrying out the initial assessment, prioritising for treatment, and co-ordinating care, the nurse completes a nursing assessment, initiates interventions and evaluates nursing care delivery to a caseload of service users.

The nurse works in a variety of settings, which can influence the degree of primary care delivered. However, the following common interventions and educational inputs are provided by the nurse in the IPS to all service users:

- Virology for HIV/Hepatitis screening
- Administration of methadone.
- Vaccination regime as per protocol
- Assessment, treatment and management of tissue viability
- General health promotion
- Family planning and safe sexual practices
- Education on HIV/Hepatitis

Role of the Pharmacist

The Pharmacist is responsible for the dispensing and administration of methadone in the prison, for the stock control and ordering of methadone, as well as ensuring that records of all methadone use are maintained as legally required. She/he will also have a significant role to play in the management of lofexidine detoxification procedures, as necessary. The Pharmacist also provides advice for clinicians and nurses on pharmacology and drug interactions of medications, and will work as part of the multidiscliplinary team.

Record keeping

Each intervention should be properly recorded and thorough, clearly written or computer records of prescribing should be kept (In accordance with IPS and An Bord Altranais Guidelines). Other medical staff members who may see the service user should be informed of current treatment.
There is enormous variation in regulations about confidentiality throughout Europe. A central register where people receiving methadone are notified exists in this jurisdiction. This register should not entail notification to any non-medical service or institution in accordance with the regulations governing the Central Treatment List (CTL). Its main purpose is to protect the service, the service users and the service providers as well as to prevent multiple prescribing and to facilitate research or funding decisions (Irish Guidelines, 1997). Notification to the CTL is mandatory and should be complied with in full, as per the regulations.

Dispensing

The person whose name is on the prescription should be the only person to present for the prescribed methadone. Where possible methadone should be administered to the patient prior to his leaving the prison for court or other appointments or discharge. At all stages of treatment in prison, methadone should be dispensed and supervised on a daily basis by a Pharmacist or two nurses in the absence of a pharmacist.

Other services

As previously stated, the success of methadone treatment is partly influenced by the availability of other services apart from pharmacotherapy. The importance of counselling and psychotherapy has been discussed above. Liaison with other medical and social services have also been discussed elsewhere in this report. In case of co-morbidity, contact with other services should be encouraged and possibly co-ordinated by the staff of the drug team.

It is considered part of the treatment programme to try to resolve any social, legal or medical problems. Other drug dependence services, namely the availability of clean injecting equipment either for sale or exchange and information on health and other risk behaviour, can form a welcome addition to the treatment programme. Finally, the presence of an outreach project in the area can be helpful in contacting people who do not come to the existing services as well as keeping abreast of what happens on the drug scene.

Physical setting

A first condition for a programme is that it is safe. Safe in the sense that people can trust the workers and that personal information is treated according to medical standards and is not given to third non-medical parties. It may seem obvious, but essential for a successful programme is that people are being treated with respect and that their privacy is ensured.
A non-judgemental attitude of treatment staff is important. Some research has shown that in a methadone maintenance programme where the staff can be identified as "abstinence orientated" service users will leave quicker than when a programme is maintenance orientated. This difference ensued after correcting for methadone dosage. (Vosseberg, 1998)
Another obvious pre-requisite for any medical service is that premises are clean. It is recommended that all staff involved in the treatment of opioid dependence be immunised against hepatitis B and undergoes tuberculosis screening.

Monitoring and Evaluation

A great deal of research has been carried out on the different aspects of methadone treatment. Monitoring and evaluating services and programmes are an essential part of good practice. Most programmes will have some system of monitoring their activities: how many people are seen, with what frequency, how much methadone is prescribed, etc. However, evaluation of the treatment outcome or a costs-benefit analysis of treatment is rarely carried out.

One can argue whether a treatment that has shown to be efficacious, needs to be evaluated over and over again. The goal of the afore-mentioned Cochrane Collaboration is precisely to prevent having to 'reinvent the wheel' by providing the available on the electronic library published quarterly (http://www.updatesoftware.com)

However, we have seen that the way in which treatment is offered is important for its outcome. It is therefore important that any service offered to the public should have a mechanism to evaluate its own success. It is important to have checking mechanisms to see if the different professionals are doing their work appropriately, or whether individual service users who are admitted into treatment are suited for that particular type of treatment.

Monitoring of the different activities should be common practice in any programme. Keeping records of activities is therefore essential, but even more important is giving attention to analysing these data. A descriptive analysis on the basis of the monitoring of activities is always possible and when set off against the costs of a given intervention, a cost-benefit analysis can be made.

For any type of evaluation of a given intervention it is essential to formulate a clear question, to define the objectives a priori and to assess the need of such intervention. Furthermore, it is essential to verify whether you are measuring what you want to know.

In addition to the well-known quantitative methods of evaluation, such as monitoring of activities and making a descriptive or cost-benefit analysis, one can consider other types of instruments. A survey could be carried out among service users based on a questionnaire in order to check if service users are happy with what is being offered and the way in which it is offered to them.

Assessment of the quality of the service could be measured with more qualitative instruments, such as through a 'focus group', or in-depth interviews with workers, service users, consumer groups, neighbours, community leaders, police, etc.
It is always useful to involve external experts for this type of evaluation. Market researchers, management consulting or consumer groups could provide welcome suggestions to improve service delivery.

Evaluation should be an integral part of programmes, possibly by independent experts, and the results of these evaluations should be taken into account when designing new programmes. In this field, the European Monitoring Centre for Drug and Drug addiction has issued, and will continue to issue, guidelines for evaluation of activities and models for the assessment of policies (Council of European Union, 1999).

All evaluations internal and external should be appropriately disseminated to the all-relevant staff involved.

5. GUIDANCE FOR HEALTH CARE STAFF IN RELATION TO THE RESPONSIBILITY TO SAFEGUARD THE CONFIDENTIALITY OF MEDICAL INFORMATION CONCERNING PRISONERS

(Taken from IPS Healthcare Standards – Administrative Policy 2)

INTRODUCTION

The Irish Medical Council[1], An Bord Altrainais[2], and the Pharmaceutical Society of Ireland[3] in their various guidances highlight the fact that confidentiality is a time honoured principle of professional healthcare ethics and is fundamental to the therapeutic relationship. Developments in various aspects of the practice and administration of health care have led to reconsideration of the issues involved[4,5,6]. Various national[1] and international statements[7,8] on the issue of ethical behaviour as applied to prisoners clarify that prisoners must be treated in the same way as other patients. There is no diminution or derogation of professional responsibility in this respect when providing care to prisoners.

Notwithstanding the fact that patient confidentiality is difficult to maintain in the prison setting it is, nevertheless, the responsibility of healthcare staff to ensure that a patient's right to confidentiality is respected. While a sick prisoner cannot easily prevent the nature of an illness being known to others sharing a cell or by prison officers this process should not be facilitated by unauthorised disclosure by healthcare staff. Any presumption that discipline staff or others, because of their position, are entitled to unimpeded access to information regarding a prisoner's health status must be clarified.

CORE PRINCIPLES

1. Information relating to a prisoner's health status should be restricted to those with a genuine need to know.
2. Any sharing of information amongst those who do need to know should ordinarily be with the prisoner's consent, though exceptions may arise (see below).
3. All clinical interviews and examinations should be conducted out of the hearing and sight of prison officers unless the doctor or nurse concerned requests otherwise in a particular case.

EXCEPTIONS

1. Notification of infectious diseases under the relevant Health Acts.
2. Disclosure ordered by a Court.
3. Disclosure to prevent risk to the patient – should be case specific and limited to relevant staff.
4. Disclosure to prevent risk to others – would require a real and imminent risk to an identified individual. The risk would have to be considered life threatening to sustain a decision to disclose confidential information.
5. Child protection – under terms of relevant child protection legislation.

REFERENCES –

1. A Guide to Ethical conduct and Behaviour. 5th Edition 1998. Medical Council.
2. Code of Professional Conduct for each Nurse and Midwife. January 1988. An Bord Altrainais.

3. The Practice of Pharmacy Guide. Pharmaceutical Society of Ireland, 1999.

4. Confidentiality: Protecting and Providing Information. September 2000. General Medical Council.

5. Confidentiality: A Code of Practice for NHS Staff (Consultation Draft). October 2002. Department of Health (London).

6. Protecting Patient Confidentiality – Final Report. (Confidentiality and Security Advisory Group). Scottish Executive Health Department, 2002.

7. Recommendation No. R (98) 7 of the Committee of Ministers to Member States concerning the Ethical and Organisational Aspects of Health Care in Prison. Council of Europe.

8. Guidelines for Health Care Services in Prisons. CPT 3rd General Report (1993).

6. CRITERIA FOR TREATMENT PRIORITY

A patient who is considered a treatment priority will commence methadone treatment as soon as it is safe for them to do so (after a definite diagnosis of dependence to opiates has been established or in a number of cases confirmed from associated outside agencies).

Patients will be prioritised for treatment under the following circumstances:

- **Patients in receipt of prescribed methadone from other agencies**
  Confirmation must be sought from the prescribing agency in relation to type of methadone substitution treatment, the current dose and last time and date of administration

- **Pregnancy**
  A confirmatory pregnancy test must be performed before initiation of methadone treatment

- **Physical illness**
  To include:
  1. Patients who are HIV positive
  2. Patients who are terminally ill
  3. Sub acute bacterial endocarditis
  4. Deep Vein Thrombosis or Pulmonary Embolism attributable to intravenous substance misuse
  5. Patients who are HCV positive who have been scheduled for treatment or who have commenced treatment that have subsequently destabilised and have a well-defined past history of opiate dependence
  6. Patients who have a serious physical illness where continued substance misuse could potentially be life threatening

  (in all of the above circumstances written confirmation of the diagnosis is required before initiation of methadone treatment)

- **Blood borne virus risk**
  Patients who following a comprehensive assessment are considered at serious risk of acquiring or transmitting a blood borne virus

- **Patients under 18 years**

- **Patients with learning disabilities**

  Confirmation and further information should be sought from outside agencies where applicable or the patient must be assessed and diagnosed by a psychiatrist or psychologist as having a learning disability

- **Patients with a psychiatric condition**
  - Patients with a major psychosis or depression (diagnosed)
  - Suicidal patients following a psychiatric assessment and recommendation to initiate methadone

- **Cases falling outside the above criteria**
  Where cases fall outside the above criteria a doctor can, in consultation with a consultant specialist in substance misuse or appropriately experienced addiction specialist, determine a patient to be a treatment priority and initiate methadone treatment.

Before a methadone maintenance programme is initiated a treatment place must be sought from and confirmed with the community agency who will provide follow-up care and methadone prescribing on release from prison.

If a patient is commenced as a priority this must be clearly documented in their notes indicating the name of their community clinic. This information must to be transferred with the patient on any movement within the IPS.

7. CENTRAL TREATMENT LIST

1. It is the legal requirement that all patients prescribed methadone (either as a detoxification or a methadone maintenance programme) are registered on the Central Treatment List before commencing treatment. It is the responsibility of the prescribing doctor to ensure that the patient is entered and voided from the Central Treatment List.

2. Weekly contact with health care staff from the prison with staff in the Central Treatment List would ensure that the names of patients on methadone are kept up to date.

3. Once a patient discontinues methadone treatment or is released from prison, their name needs to be voided from the Central Treatment List.

4. The contact number for the Central Treatment List is 01-648 8600.

8. TOXICOLOGY SCREENING OF URINE

INTRODUCTION

The rationale for employing toxicology screening in the IPS is an effort to provide a safe secure environment for persons in custody, to identify those who may be in need of drug treatment.

Urine toxicology screening can be used as an aid to assessing the level of addiction and/or need for treatment, monitoring therapeutic measures and ensuring compliance.

This policy document will outline best practice guidelines in relation to such screening. It will take cognisance of issues such as procedures, process, personnel, training, facilities, recording and storage of results as well as issues of informed consent.

FREQUENCY

The frequency of urine samples will depend on the purpose of the urine screen. All committals to prison, where there is concern about drug or alcohol abuse, should be screened prior to seeing the doctor.

- The Methadone treatment Guidelines indicate that during assessment for treatment a series of samples be taken. It is recommended that 3 samples over a period of 10 days be taken (divided evenly over the ten days and one of which should be tested for 6-acetyl-morphine).
- Patients who are unstable should be screened twice weekly. Those stable on Methadone Maintenance should be screened randomly on a weekly basis.
- Those on a detoxification programme, or not yet authorised on Methadone should be screened as clinically indicated.

Frequency of Testing.

	Reason for Urine Screening	Duration	Frequency
1	Court report	As dictated by courts.	As dictated by courts
2	As part of a methadone maintenance programme	Duration of Treatment	At least once weekly.
3	To identify those who may be in need of drug treatment	On committal	Dependant on committal test results and recommendations of clinician.
4	To assess for Methadone Maintenance Programme.	10 Days	3 samples over the designated period one of which should be tested for 6-acetyl-morphine (6AM).

METHOD

Drug Screening may be conducted in one of two ways i.e. Near Patient Testing (NPT) / dip-stick and Laboratory Testing. Laboratory testing provides the clinician with external, objective, documentary evidence which will be upheld by the biochemists analyzing samples. This is a consideration when choosing a method of testing. Clinicians will require confirmatory testing by a laboratory.

	Reason for Urine Screening	Initial Test	Confirmatory Test
1	As part of a methadone maintenance programme	Laboratory Testing	Not Applicable
2	To identify those who may be in need of drug treatment	NPT or 'Dip Stick' technology	Laboratory Testing
3	Induction to substitution treatment.	Laboratory Testing	Laboratory Testing

If on testing a sample, on committal, using the Near Patient Testing method a positive result is obtained, confirmation by Laboratory Testing should take place.

FACILITIES

Appropriate facilities will be installed in all prisons to allow urine sampling take place in line with best practice in a controlled environment.

This procedure should be carried out with the utmost regard for the dignity of both the patient and the individual supervising the process.

The following facilities must be made available: -

1. A specially adapted room where only urine samples are taken,
2. This room should be fitted out with toilet, appropriate hand washing facilities, mirrored walls, extractor fans.
3. Second room, ideally should be linked to the urine sampling room, in which urine samples can be processed for dispatch to laboratory and where NPT can be processed if necessary. This room should have wash hand basin, lockable storage facility, appropriate testing equipment, safety equipment, and adequate facilities for any necessary clerical related work.

RECORDS

Accurate record keeping is an integral part of any urine screening process, particularly when on site testing is carried out. Decisions regarding the patient's medical treatment may be made on the basis of these results. The records of all medically initiated testing should be held in the patient's medical file. **Records of tests carried out for other reasons should be held by the appropriately assigned personnel under the auspices of the governor of the institution.**

The recording of all samples taken, tested and results given is of great importance. A register of all tests carried out and results obtained should be maintained by healthcare staff/healthcare administration. Scrupulous attention to detail is required in the taking, labelling, handling and recording of particulars surrounding the urine screening process. In order to effectively deal with the volume of data that the urine screening will generate it is important that all such data is stored on a database, Prisoner Medical Records System (PMRS).

Responsibility for maintaining the primary on going records of tests done outside the institution e.g. laboratory testing, is the responsibility of the testing laboratory.

PERSONNEL

The screening of urine is not a medical procedure and as such can be carried out by any competently trained individual. **The procedure should be carried out with the utmost regard for the dignity of both the patient and the individual supervising the process.** Due regard should be taken of the gender of the individual being screened and appropriate arrangements made to have same sex personnel involved. Arrangements should be made to train all staff involved in screening urine. Appropriate chaperoning arrangements should be in place in the interests of both staff and patients.

MANAGEMENT OF URINE RESULTS

It is not the philosophy of treatment providers to use urine test results to sanction patients. The clinician in charge of his/her cohort of patients will designate how urine test results will be acted on for his/her patients.

Urine results may result in adjustment of methadone dose upwards or downwards depending on clinical circumstances. Dose adjustments need to be made only following a valid prescription.

URINE DECLINES

The clinician will have designated an immediate adjustment to the methadone dose, if any, for their own patient group. Any adjustment must be reflected in a valid prescription in the absence of pharmacists. The clinician may provide written policy for their patient group.
It is the policy of the IPS to standardise the methadone dispensing arrangements which in turn will facilitate standardisation of all processes relating to Methadone.
Repeat refusals should be brought to the attention of the prescribing doctor.

POSITIVE URINES

It may be necessary for adjustments to be made to methadone doses on clinical presentation and/or urine results. This adjustment must be made, by the prescribing clinician and with a valid prescription. The clinician may provide written policy for their patient group.

Confidentiality of medical urine results are guided by confidentiality policy.

Appendix 2 – Urine Screening Procedure

9. USE OF METHADONE – ORDERING, DISPENSING, ADMINISTRATION AND RECORDING OF METHADONE.

INTRODUCTION

Methadone is controlled under Schedule 2 of the Misuse of Drugs Acts 1977 and 1984 and subsequent Regulations (1988 and 1993). It is therefore necessary to ensure compliance with the legal requirements set out in this legislation. This document does not purport to be a legal interpretation, but is rather a guide to best practice in relation to the use of methadone.

Ideally all aspects of methadone usage – ordering, storage, administration, recording etc should be managed by pharmacists.

In the current absence of any on-site pharmacists, methadone will continue to be supplied to the doctor in each prison for use in that prison and s/he can delegate responsibility for the use of methadone to the healthcare staff. A new contract has recently been agreed with for the supply of methadone jointly to the IPS and the HSE, and the following procedures have been agreed to ensure compliance with all legal requirements.

These procedures are applicable in the absence of pharmacists.

NOTE:

In the absence of a pharmacist, where a nurse is on duty, s/he will be held responsible for the safe custody of Controlled Drugs and compliance with the regulations.

RECORDING:

Register:

- A complete record must be kept of every transaction involving methadone.

Administration

- Recording of administration should be carried out by the pharmacist or the two nurses involved in administration.
- **As a daily record of the administration of Methadone is kept, it is acceptable to make a single daily entry in the register for the total amount of methadone dispensed each day.**
- <u>The register and the daily issue forms constitute the complete record for the use of Methadone.</u>

Receipt:

- A record of each new supply of methadone received must be made in the controlled drugs register, stating date, supplier, and quantity received.
- The stock balance should be adjusted accordingly.
- This entry must be signed by the pharmacist/ two nurses.

PRESCRIPTION

Methadone may only be administered on foot of a current valid prescription.

ADMINISTRATION

a. Methadone may only be dispensed and administered on foot of a current, valid prescription.
b. Ideally methadone should be dispensed and administered by Pharmacists.
In the absence of Pharmacists, dispensing and administration of methadone should be conducted by two Nurses.
c. Before administering methadone to a patient, the Nurse:
    1) check the patient's name, photograph, number and location
    2) check the medication against the prescription
d. All methadone administration must take place in front of the Nurse.
e. To ensure that the patient has swallowed the dose of methadone:
    1) Each patient should take a drink of water after each dose of methadone
    2) The patient should be supervised, in so far as is possible, to ensure that the methadone has been swallowed
    3) The patient should be engaged in conversation following medication administration, to assist in confirming that the methadone has been swallowed.
    4) Any suspicion of retention of methadone should be reported to the doctor.
f. Any wastage of controlled drugs should be recorded and the entry witnessed.

g. A signed record should be appropriately entered on the patient's file on PMRS.
h. The checking, preparation, administration or destruction of controlled drugs should be witnessed.

TREATMENT OF OVERDOSE
Narcan

Facilities should have available to all health care staff protocols to treat acute opioid overdose. If there are no facilities and/or staff to treat and observe a patient who has overdosed on methadone for at least 24 hours, the patient should be transferred to another suitable facility.
Naloxone (Narcan) should be available in all Prison Service Surgeries and may be administered, where appropriate, by clinical staff as outlined in the "IPS Clinical Guidelines on the use of Narcan in the treatment of opioid overdose" – Appendix 3.2 of IPS Healthcare Standards.

NON-INGESTION OF METHADONE
If vomiting takes place:
while the patient is in the administration area **and** within 10-15 minutes of administration **and** is observed by healthcare staff **the full dose is replaced**.

If vomiting takes place:
within 15-30 minutes of administration **and** is observed by prison staff
a half dose is administered.
It is important to record this in the Daily Administration Sheet and in the patient's file on PMRS.

If vomiting takes place:
after 30 minutes no **replacement dose is administered**.

Appendix 3 – Use of Methadone Processes
Appendix 4 – Disposal of Patient's Legally Dispensed Methadone

10. MANAGEMENT OF VIRAL INFECTIONS

All patients should be offered and have completed a full viral screen within a month of incarceration. Refusals should be documented.
Those found to be negative for the following viruses should be managed as follows:

Hepatitis A virus – Receive vaccination with Havrix or Twinrix.

Hepatitis B virus – Should have vaccination status checked and completed as appropriate. Should receive information on how hepatitis B virus is transmitted and ways to protect themselves from being infected. This advice should be documented in the chart.

Hepatitis C virus – Receive information on modes of transmission and how they can protect themselves from being infected. This should be documented in the chart.

HIV virus - Receive information on modes of transmission and how they can protect themselves from being infected. This should be documented in the chart. All patients who test negative for any of the above should be advised of the window period of infection and if they had risk of exposure in this period. They should then be advised of the necessity to retest. Patient should also be advised of their potential risk of infecting others during this period.

If patients test positive for the following virus:

Hepatitis A – Reassured of nature of infection and of benign course

Hepatitis B – Those diagnosed Hep B positive should be checked for E Antigen. If found to be positive should be advised of infective nature and should be referred for consultant review. Potential contacts should be offered testing. (More appropriately done by Hepatology service)

Hepatitis C virus – Those found to be positive should be offered a PCR test with genotyping. If found to be PCR negative should be advised of possibility of re-infection and ways to avoid infection. They should have a re-test done after year. Infection should be notified to the public health department.

If PCR positive patient should be assessed for suitability for treatment or assessed for needs to have a specialist opinion (e.g. alcohol abuse, dual infection) even if not deemed suitable for treatment.

The patient should be made aware of current criteria for eligibility for Hep C treatment (drug stable etc.) and advised of need to work towards fulfilling the criteria. Patient should be advised of other liver toxins (alcohol, drugs etc.). Patient should be advised of their potential to infect others and should have a discussion around risk of sexual transmission, sharing of razors, toothbrush, etc. Those deemed suitable for treatment should be referred directly to local hepatology service.

After appropriate linking and follow up with hepatology service liaison should happen between drug treatment service, hepatology and Hep C liaison nurse. Treatment option will depend on clinical criteria, patient and treatment setting. All patients undergoing treatment need to be monitored closely by both hepatology and drug treatment service and should be offered appropriate support and interventions as required.

All patients diagnosed HIV positive should be offered post test counselling and support and should be referred to local consultant HIV services. Close monitoring and liaison should occur between services, and monitoring of CD4 and viral loads and or appropriate therapy interventions. Liaison should be very close on patients where compliance may be an issue. Directly observed treatment should be utilised in a prison setting. Potential contacts shall be offered testing and appropriate follow up. Appropriate forms need to be filled out and sent to the virus reference laboratory.

11. IMMUNISATION GUIDLEINES

(Taken from IPS Healthcare Standards – Healthcare Standard 6 Communicable Diseases)

Standard

1. All programmes of immunisation offered to prisoners will be in line with national guidelines recommended by the Department of Health & Children or by the HSE.

Criteria

The responsibility for the application of the vaccines programme lies with the Primary Care Team.

Hepatitis B immunisation will be offered to prisoners in line with prevailing policy guidelines.

Hepatitis A vaccination will be offered to prisoners who are Hepatitis C positive and do not show evidence of previous Hepatitis A infection.

Meningitis C vaccination will be offered to prisoners under the age of 23 years who have not previously received this immunisation. (See HC Policy C/6 - 'Meningococcal C Immunisation Programme').

Young offenders who have not completed their programme of school-based immunisation will be offered the opportunity to complete these.

Other immunisation programmes will be offered in line with pertaining Public Health guidelines. (See HC Policy C/7 - 'Influenza Vaccination for Prisoners').

Immunisation Guidelines for Ireland – 2002 Edition

Available on:
www.dohc.ie/publications/immunisation_guidelines_for_ireland.html
www.ndsc.ie/Publications/Immunisation/ImmunisationGuidelines
or in each surgery.

Anaphylaxis packs, containing Adrenaline, must be available at all times before giving vaccines.

See Appendix 3.3 - "Best Practice Guidelines in the Management of Anaphylaxis"

12. HIV TESTING

Any patient who requests HIV testing should be able to avail of it within the prison medical service.

Particular risk groups for HIV should be targeted for testing because of the availability of very effective early intervention for HIV disease. These groups include Injecting Drug Users (IDU) and partners of IDU, men who have sex with men (MSM) and prisoners from high endemic areas for HIV (sub-saharan Africa etc.). Patients who have tested previously should be offered retesting **observing a 3 month window period from any new risk**.

While some patients may welcome the opportunity to test some feel that they could not cope with a positive result while incarcerated. Pre-test discussion should be available for those who are deemed by the clinician to require it. Patients who **may** require pre test discussion are those belonging to high risk groups, those with an intellectual disability, those where English is not their first language and those with undue anxiety.
Pre-test discussion may be undertaken by the healthcare staff.

The issues which should be covered during a pre-test discussion session for HIV are as follows.

1. Modes of acquisition and transmission of HIV
2. Patient/client's own risk of acquisition.
3. Natural history of HIV, emphasising the very positive outlook at this time.
4. What social /family support available to the patient in the event of a positive result. Possible impacts on partner, family members etc.
5. Issues around life insurance, mortgage protection etc.
6. Issues around employment – i.e. no issue for employment except for surgery/dentistry.

Phlebotomy for HIV testing and other routine bloods should be available within the prison health care unit.

Confidentiality is of the utmost importance and no one other than the staff directly involved in testing should be aware that a patient is having a HIV test.

13. ADMINISTRATION OF HIV MEDICATIONS

Correct administration of antiretroviral medication (ARV) and 100% compliance with ARV is absolutely crucial to the long term prognosis of HIV. The principles of HIV therapy are as follows:

The virus has the ability to **mutate** itself in the presence of antiretroviral medication to make it resistant to the medication. Historically it is known that where AZT is used alone **resistance** develops to the drug in about 6 months. Resistance to other ARV can develop much more quickly – even after one dose e.g. Nevirapine (Viramune)

Three or more drugs are usually used together in an antiretroviral regime. Using 3 drugs drives the virus load down so low in the blood that the virus cannot acquire the mutations it needs to develop resistance.

More than 95% of doses must be taken correctly to maintain viral susceptibility to medication. Some pharmaceutical companies own more than one drug and may have combined 2 or more drugs into one tablet so the patient may be taking 3 drugs while only taking one tablet twice a day. E.g. Trisivir contains AZT, 3TC and Abacavir. Reducing pill burden improves compliance.

Discontinuation of ARV should be in consultation with the treating hospital as there are very significant differences in half lives of ARVs and they may need to be discontinued in a staggered fashion. If a prisoner declines to attend their hospital appointment contact should be made with the HIV pharmacist in the Mater, St. James or in Beaumont for advice on discontinuation.

Some drugs require to be taken **fasting** e.g. DDI and some drugs must be kept in the **fridge** e.g. Ritonavir. Ideally ARV in prison should be administered on a **directly observed therapy (DOT)** basis by a pharmacist.

There are very significant **interactions** between ARV and other medications e.g. Proton pump inhibitors (losec) cannot be co administered with Atazanavir.
If any patient on ARV requires co administration of other medication the HIV pharmacist in the relevant hospital should be contacted. (There is usually no problem with co administration of antibiotics).

Side effects to ARV which are often prevalent in the first month of therapy usually subside over time and it's important to support the patient through this.

Efavirenz (Sustiva) is teratogenic and should not be administered in anyone contemplating a pregnancy.

Some **ARV interact with Methadone** requiring an increase or decrease in Methadone dose. The treating HIV team should inform the prescribing doctor if this is the case.

Any antiretroviral therapy supply left when a patient is released should be transferred to the patient's drug treatment centre or if s/he is not attending for drug treatment returned to the treating hospital. Patients who are released should have enough medication to last them until they can reasonably expect to be seen and have their prescription renewed.

Three monthly follow up at the hospital outpatients is the norm for HIV patients and it is very important that appointments are kept. Patients should not be allowed to continue antiretroviral therapy if they are not attending for hospital follow up.

All HIV medication will be dispensed by the treating hospital.

14. ASSESSMENT AND TREATMENT OF BENZODIAZEPINE ADDICTION IN PRISON: BENZODIAZEPINE DETOXIFICATION GUIDELINES

Assessment of benzodiazepine misuse and dependence in an IPS Setting. Medically assisted detoxification, ongoing BDZ prescribing and use of anticonvulsant medications to cover Benzodiazepine withdrawals

1.0 Background

1.1. **Misuse of benzodiazepines is an endemic problem in the Irish Prison population**. **The majority of prisoner patients will not require a medically assisted detoxification or an ongoing prescription for benzodiazepines. However they will require assessment of their levels of use and dependence on benzodiazepines and a documented clinical decision in respect of the assessed need for detoxification. If a diagnosis of benzodiazepine dependence is made then these patients should be offered a medically assisted detoxification.**

1.2 Benzodiazepines were developed in the last century and came into therapeutic use in the 1960s. Initially they were thought to be without a potential for misuse or dependence but by the early 1970s it became clear that these agents had a significant potential for both misuse and dependence

1.3 Accordingly expert guidance on the rational and appropriate use of benzodiazepines has tightened. The usual significant indication remains the short term treatment of significant and disabling anxiety problems and/or disturbance of the sleep wake cycle. Both the recent Guidelines from the Department of Health and Children in the Republic and the internationally respected UK British National Formulary (BNF) suggest that initial use should be restricted to a 2 to 4 week period. For those patients who are dependent on these drugs it suggests a gradual process of dose reduction in community settings.

1.4 In the Republic of Ireland there currently exists no specific extended regulation of the prescribing of Benzodiazepines. Use of these agents is amongst the highest levels in Western Europe. Misuse of these drugs is very significant and the majority of prisoner patients with a drug problem will have used benzodiazepine drugs at some point. Only those prisoner patients who meet the criteria for benzodiazepine dependence will require a medically assisted detoxification.

1. 5 Benzodiazepines in Irish Prison settings.
Ideally prescribing of these medicines would be minimal and time limited. Significant progress has been made to rationalize the use of prescribed BDZs in IPS locations in Dublin. Illicit supplies are and remain plentiful in prison settings. In the context of prison these medicines have a currency. They may be used to barter for other goods or services. Prisoners on benzodiazepines may and often are bullied to surrender their supply to other prisoners. Benzodiazepines can have disinhibiting effects that are often associated with aggressive behaviours directed at other prisoners and staff. A link has been argued to exist (by some Clinicians) between self harming behaviours and benzodiazepine use in prison settings. A binge pattern of benzodiazepine use makes it very difficult to stabilize patients other drug use. When prescribed rationally with resulting therapeutic levels the use of prescribed benzodiazepines is not incompatible with psychological work. Comorbid psychiatric disorders (mood, anxiety or psychosis) may be present, and should be considered in the diagnostic work up of patients seeking to obtain benzodiazepines. Adjustment reactions to psychosocial stressors also occur and are usually better treated by referral to Counselling services (if they exist locally).

2.0 Assessment of Benzodiazepine use

2.1 Nursing assessment

As part of the comprehensive Nursing assessment the following should be documented -
Enquiry should be made as to the level of use and the agents involved.
(a)I.e. What agent,
What quantities,
What frequency,
When last used
If ever withdrawal seizures.

(b)Concomitant alcohol use should be noted
What alcohol type
What quantity
What frequency
When last used
Ever had withdrawal fits

Ever had DTs
Screening tools such as the AUDIT may also be used.

(c) A prior history of seizure activity should be recorded and the context involved.

(d) Enquiry should establish if there are any prescribed BDZs and the Community or Specialist prescriber involved.

2.2 If a patient is clearly in withdrawals (tachycardia, elevated BP, tremor) and gives a history of alcohol or BDZ use a protocol should be agreed locally in each Prison between Nursing, Pharmacy, General Practice, and Addiction Psychiatry that would enable Nursing staff to administer a long acting Benzodiazepine(,e.g. diazepam or chlordiazepoxide) before a Medical Assessment.

Emergency Administration Protocol
If a patient who has given a history of benzodiazepine or alcohol use becomes clearly
Tremulous
Sweating
Has a tachycardia (pulse > 90)
Normal or elevated blood pressure

Nurses may administer benzodiazepines on an emergency basis. A protocol for emergency administration will be agreed locally.

2.3 Assessment by GP
This essentially confirms and extends the Nursing Assessment. At the completion of both assessments there should exist in the notes a description of last use, agents and quantities used, usual pattern of use and corroboration of prescribing from Addiction Treatment Centre, GP, Consultant Psychiatrist or the DTCB.

3.0 Treatment of Benzodiazepine withdrawal

3.1 All prisoner patients who are assessed as having a current pattern of BDZ dependence (as opposed to misuse) should be offered a time limited medically assisted detoxification and this should be documented in the medical notes. If a prisoner does not meet the ICD-10 Criteria for Benzodiazepine Dependence at the time of the assessment this should also be documented in the medical notes.

3.2 There are several options in respect of the choice of agent to assist in withdrawal from Benzodiazepines. Essentially these presently are (a) to use a long acting benzodiazepine such as diazepam and reduce slowly in decremental manner or (b) Use of anticonvulsant medicine such as sodium valporate in those patients on methadone or carbamazepine in those who are not methadone maintained. The latter agents are used off label and off license but clinical experience exists to support this strategy subject to the usual cautions and contraindications for both agents (e.g. allergies, active liver disease etc).

3.3 Suggested detoxification regimes

(a) Liquid formulation of long acting Benzodiazepine e.g. diazepam 10mg - 15 mg TID and reducing by 05mg every three days.

Day 01 Diazepam 15mg TID (morning, lunch time and night)
Day 04 Diazepam 10mg-10mg-15mg
Day 07 Diazepam 10mg-05mg-15mg
Day 10 Diazepam 10mg-0mg-15mg
Day 13 Diazepam 05mg-15mg
Day 16 Diazepam 15mg nocte
Day 19 Diazepam 10mg nocte
Day 21 05 mg nocte
Day 25 Cessation of medically assisted detoxification

Or

(b)

Day 1 Sodium valporate 200mg tid
Day 02 Sodium valporate 400mg tid
Day 03-10 Continue as above
Day 11 Sodium valporate 400mg bd
Day 13 Sodium valporate 200mg bd
Day 14 Sodium valporate 200mg nocte
Day 16 Cease

3.4 If the level of BDZ use is reported as very high, and significant withdrawals are observed the adjunctive use of Sodium valporate is suggested in addition to a long acting benzodiazepine (see current BNF for dose induction recommendations, usual dose 1200mg daily in divided doses) and the period of dose reduction may be extended under medical supervision.

4.0 Ongoing assessment

4.1 Regular review is necessary as the patient may have either overstated or understated their levels of use. At a basic minimum the patient should have a documented nursing review with documentation of vital signs and seizure activity on a daily basis and be medically reviewed every 72 hours.

4.2 If a patient presents as oversedated the dose reduction may be accelerated following medical review.

5.0 Use of Carbamazepine in opioid dependent patients on methadone therapy

5.1 Carbamazepine (CBZ) should not be prescribed for any patient who is on any methadone programme (stabilization, maintenance or reduction) as there is a well documented interaction and increased metabolism of methadone.

6.0 A minority of patients who are under the care of ether Consultants in General Adult Psychiatry or Consultants in Addiction Psychiatry may be on an extended non time limited prescription for BDZs. This should be confirmed with the relevant Consultant and an individualized care plan drawn up in agreement with the Consultant Psychiatrist in the community to manage these patients' ongoing care. The option of a medically assisted detoxification in addition to the option of ongoing benzodiazepine prescribing may be considered and the final decision documented in the medical notes.

References

Benzodiazepines: Good Practice Guide for Clinicians (2003) Department of Health and Children, Ireland

A. R. Lingford-Hughes, S. Welch, and D. J. Nutt, Evidence-Based Guidelines for the Pharmacological Management of Substance Misuse, Addiction and Comorbidity: Recommendations from the British Association for Psychopharmacology, ***Journal of Psychopharmacology*, 293-335, Vol. 18 (3), September 2004 by SAGE Publications Ltd.** http://jop.sagepub.com

British National Formulary 53 (BNF), www.bnf.org, British Medical Association and the Royal Pharmaceutical Society of Great Britain.

Clinical Management of Drug Dependence in the Adult Prison Setting (2007) Department of Health, UK.

Benzodiazepines: risks, benefits or dependence; a re-evaluation. Council Report CR 57. London, Royal College of Psychiatrists, 1997.

Benzodiazepines: dependence and detoxification pp198-199 in The Maudsley 2005-2006 Prescribing Guidelines(Eighth Edition).Eds Taylor, D., Paton, C., & Kerwin,R. Taylor & Francis, UK.

15. PRESCRIPTION OF HYPNOTICS

Some patients request from the GP to be prescribed night-time sedation. In many instances sleeping tablets have been prescribed to these patients or obtained by them in the community on a regular basis. Committal to a prison can be a very traumatic event which causes great anxiety and often sleep disturbance.

Some points to be considered for prescribing clinicians:

- There is no absolute indication for the prescription of night-time sedation
- Long term sleeping tablet use has been shown to decrease the quality of sleep obtained and for this reason short term use only is recommended. This is particularly the case with benzodiazepine (BDZ) sleeping tablets.
- As with the use of BDZ's for anxiety, the use of sleeping tablets encourages a 'quick fix' mentality which allows more important issues (social, relationships, depression, anxiety, lifestyle) to remain unaddressed.
- Sleeping tablets have a currency within the prison system and the bartering of them can be a source of confrontation/bullying between prisoners.
- Many patients have substance abuse problems and the use of sedatives represents an aspect of these problems.

With these points in mind reasonable clinical policy would support:

1. No BDZ sleeping tablets to be prescribed.
2. No zopiclone sleeping tablets to be prescribed. (Although these are non-BDZ, they have currency in the system at present).
3. Other sleeping tablets (Phenergan, Stilnoct, Sonata) to be prescribed on a strictly limited basis e.g. for a short period of time after committal to allow for adjustment and then discontinuation.
4. Counselling with regard to sleep hygiene, lifestyle, substance abuse and other factors which influence sleep should be provided and also more specific treatments associated with serious psychiatric / medical problems.
5. If a patient has a significant (predominant) night-time benzodiazepine use they will have to be withdrawn from this.

16. LOFEXIDINE DETOXIFICATION GUIDELINES
(Modified from The Maudsley's Protocol)

Exclusion Criteria

1. No patients with a history of heart disease, cerebral vascular accident.

2. No pregnant or breast feeding mothers. Pregnancy testing should be carried out and a negative result confirmed if there is any chance of pregnancy.

3. No heavy users of alcohol (more than 50 units per week for men, 35 units for women), or benzodiazapines (more than 40mg Diazepam daily).

4. No patients receiving over 10mg of methadone.

Entry Criteria

1. Blood pressure and pulse within normal limits. The systolic B.P. must not be less than 90mm Hg, nor more than 30mm Hg below the client's baseline blood pressure, before giving the dose. The pulse not below 55 beats per minute.

2. Urine sample positive for opiates/methadone.

3. Patients using quantities of less than 1/2gm of heroin daily, preferably one bag (one quarter gm) would be suitable for direct placement on Lofexidine.

4. Lofexidine is particularly suitable for young users who are smoking Heroin and who are at an early stage of drug use but who need some assistance in withdrawing from opiates.

5. Patients should first be reduced to 10mg methadone for one week at least prior to commencing Lofexidine. It is possible to use Lofexidine to take patients down from methadone. However, normally here the advice would be to reduce the methadone as far as possible, perhaps as far as 5 - 10mg before switching over to Lofexidine.

6. All clients to have attended for full assessment with nurse and GP or psychiatrist and fulfil these entry criteria and not fall into exclusion categories.

Process

1. All Lofexidine detoxes will commence on a Monday morning if possible.

2. Baseline B.P. and pulse must be taken daily and before and after dispensing of lofexidine.

3. All patients should be seen daily. The B.P. needs to be taken sitting and standing to check for postural hypotension. This should be repeated after twenty minutes. A drop of more than 30mgs Hg between sitting and standing necessitates withholding next dose and possible revision of dosage regime.

4. If systolic B.P. is below 90mm Hg or 30mm Hg below baseline or pulse is below 55 bpm discuss dose with medical staff prior to administration. It may be necessary to lower the dose and for patient to be seen in the afternoon to have B.P. and pulse monitored before night dose is taken.

5. Discuss effects of Lofexidine, including possible side effects and how these should be managed. This will also be given in writing to patients.

6. Discuss contract and consent to treatment with all patients.

7. Dispense three times daily (see protocol).

8. The Lofexidine detox will be monitored daily and the use of Withdrawal Scale Questionnaire can be used.

<u>**Dosage and Administration of Lofexidine**</u>

1. The following table shows the dose of Lofexidine that should be prescribed.

2. If patient has been on methadone ideally the dose should be down to 5 -10mg or less on the day before commencement of the Lofexidine. Those who are on Heroin should not take any Heroin in the mornings when they are about to start the Lofexidine.

Day	Morning	Lunchtime	Night	Total Daily No. of Tablets/Dose
1	1	1	1	3 tabs/0.6mg
2	2	2	2	6 tabs/1.2mg
3	2	2	3	7 tabs/1.4mg
4	3	3	3	9 tabs/1.8mg
5	3	3	4	10 tabs/2.0mg
6	3	3	4	10 tabs/2.0mg
7	3	2	3	8 tabs/1.6mg
8	2	2	3	7 tabs/1.4mg
9	2	1	2	5 tabs/1.0mg
10	1	1	1	3 tabs/0.6mg

Lofexidine tablets – 1 tablet = 0.2mg

Lofexidine – Information for Clients

What is Lofexidine?

Lofexidine is a tablet that is effective in reducing the symptoms associated with opiate withdrawal or “cold turkey” such as chills, sweating, stomach cramps, diarrhoea, muscle pain, runny nose and eyes.

Although Lofexidine does help in withdrawal it should be noted that it does not suppress all withdrawal symptoms, for example insomnia and cravings.

Lofexidine may have a mild sedative effect. Therefore it is advisable not to drive or operate machinery while on Lofexidine.

How does it work?

When opiates are stopped abruptly the brain produces too much of the chemical noradrenaline which causes the withdrawal symptoms. Lofexidine works by reducing the action of noradrenaline and so reduces the severity of symptoms.

Is it addictive?

No. It is not an opiate and has no addictive properties of its own.

How do I take it?

1. Clients using lower quantities of Heroin 1 or 2 Qs a day have the option to go directly onto Lofexidine (Patients with higher dose Heroin, ½ gm or more per day who have a Lofexidine detox may first be stabilised on methadone.)

2. The methadone can be tailed off during the first 1 to 2 days that the Lofexidine is started, but it is best if it is stopped completely before commencing Lofexidine.

3. The Lofexidine dose will be gradually built up to a maximum of 10 tablets in one day.

4. Patients present to a nurse three times a day and have their blood pressure monitored. Their blood pressure should be taken before the Lofexidine is given. The B.P. needs to be taken sitting and standing to check for postural hypotension. This should be repeated after twenty minutes. A drop of more than 30mgs Hg between sitting and standing necessitates withholding next dose and possible revision of dosage regime. Patients failing to present for medication must be followed up by healthcare staff.

5. At the end of the treatment the dosage should be reduced gradually rather than stopped suddenly as this could cause a rebound in blood pressure. Therefore it is important that clients do not drop out of treatment

without discussing it with the interdisciplinary team. If discharged prior to completion of the detox, follow up arrangements/care must be put in place.

Table showing how Lofexidine should be taken

Day	Morning	Lunchtime	Night	Total Daily No. of Tablets/Dose
1	1	1	1	3 tabs/0.6mg
2	2	2	2	6 tabs/1.2mg
3	2	2	3	7 tabs/1.4mg
4	2	3	3	9 tabs/1.8mg
5	3	3	4	10 tabs/2.0mg
6	3	3	4	10 tabs/2.0mg
7	3	2	3	8 tabs/1.6mg
8	2	2	3	7 tabs/1.4mg
9	2	1	2	5 tabs/1.0mg
10	1	1	1	3 tabs/0.6mg

6. Patients should be particularly careful when getting in and out of bed in the morning or after having a hot bath or shower as these are times when blood pressure is lowered and it is more likely to suffer the consequences of low blood pressure from Lofexidine.

Are there any side effects?

1. You may experience a dryness of the mouth, throat and nose. It would help to drink plenty of fluids (you could try some detox tea) to flush through the system and help compensate for the dryness of the mouth.

2. You may feel slightly drowsy or dizzy and if you are affected do not drive or operate machinery.

3. Lofexidine does not normally produce any significant effects on blood pressure and pulse. However, it does have potential to cause a reduction and thus your blood pressure and pulse will be carefully monitored throughout treatment.

4. As mentioned above, Lofexidine should be gradually reduced at the end of treatment to prevent the risk of rebound increase in blood pressure. Therefore patients should have a discussion with their addiction nurse prior to stopping treatment.
5. The safety of Lofexidine in pregnant women has not been established therefore precautions should be taken to prevent pregnancy during treatment with Lofexidine.

6. Lofexidine will interact with sedative drugs e.g. alcohol, benzodiazepines, heroin. Therefore, such drugs should not be used during the detox.

What should I do if I experience problems with Lofexidine?

The main problem that you could possibly experience as outlined above is a fall in your blood pressure. If this occurs you may experience the following:

Dizziness
Feeling faint
Pallor (Pale colour)
Feeling sick
Headache
Feeling drowsy

If you experience the above you should lie down fro half an hour or so and in most cases the blood pressure will return to normal. If the feeling persists you should reduce or omit the next dose of Lofexidine and discuss things with your addiction nurse or doctor.

Severity of Opiate Withdrawal Scale

Name: ____________________________ **Date:** __________________

Rate each symptom using the following scale:

0 = Nil 1 = Mild 2 = Moderate 3 = Severe

Day	1	2	3	4	5	6	7	8	9	10
Dizziness										
Difficulty Concentrating										
Feeling Faint										
No Energy										
Drowsiness										
Headache										
Dry Mouth										
Total:										

Prescription for Lofexidine 0.2mg Tablets

Medical Unit
Mountjoy Prison
Dublin 7

Patient : ___________________________ D.O.B: __________________

Day	Date	No. of Tablets 8am Issued by	No. of Tablets 1pm Issued by	No. of Tablets 10pm Issued by
Day 1		1	1	1
Day 2		2	2	2
Day 3		2	2	3
Day 4		3	3	3
Day 5		3	3	4
Day 6		3	3	4
Day 7		3	2	3
Day 8		2	2	3
Day 9		2	1	2
Day 10		1	1	1
	Total Tablets	22 +	20 +	26 = 68

Baseline Observations

Date: ______________ BP: _____/______ Pulse: _______bpm

Batch Number: __________________ Expiry Date: _________________

BP & Pulse Monitoring

DAY	DATE		8am	1pm	10pm
Day 1		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 2		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 3		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 4		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 5		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 6		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 7		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 8		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 9		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Day 10		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse
Post 20mins		Sitting	BP Pulse	BP Pulse	BP Pulse
		Standing	BP Pulse	BP Pulse	BP Pulse

Prescribing Doctor: ________________________________

17. GUIDELINES AND PROCEDURE FOR ADMINISTRATION OF NALTREXONE (NALOREX)

Naltrexone is a non-addictive opoid antagoinist capable of blocking the effects of heroin and other opioid drugs. It does not block the effects of non-opiate drugs such as cocaine or amphetamines. For 48 hours after taking the recommended dose, users cannot obtain a 'high' with opiate.

Naltrexone works by blocking opiate receptors in the brain and spinal cord.

Naltrexone blocks opiate-based pain relief i.e. cocodamol, solpadine, codeine. It can also reduce the effectiveness of opioid-based cough and cold remedies and antidiarrhoeals.

Naltrexone should form part of a programme of psychosocial support. It has been shown that Naltrexone works more effectively if counselling and support also provided.

Naltrexone must not be prescribed to pregnant women.

Guidelines for administration of Naltrexone.

Naltrexone is available as Nalorex 50mg tablets.

Careful assessment is required. Naltrexone should only be prescribed by G.P. or Consultant experienced with its use.

Naltrexone is available as a 50mg scored tablet.

If on day 10 of Lofexidine detox, or for patients who are opiate free, an-on-the-spot urine test is opiate free then the patient will be offered Naltrexone for a period of 6-12 months for relapse prevention; (provided no abnormality of L.F.T.'s)

If confident that patient is opiate free then:

- a starting dose of 12.5mgs of Naltrexone can be given.
- On day two a 25mgs tab can be given and
- on day three 50mgs and
- thereafter 50mgs on alternate days.

Administration of tablet must be supervised by the pharmacist or healthcare staff member.

Prescriptions must be written weekly.

7. When on Naltrexone liver function tests to be checked three monthly.

8. Pharmacist/Healthcare staff will provide a Medical Alert Card for service user to carry to inform re Naltrexone treatment in case of accident.

9 During this time patient to continue Counselling contact.

10 Regular monitoring for side effects is essential and patients should be reminded that their tolerance for opiates has decreased.

18. ASSESSMENT AND TREATMENT OF ALCOHOL WITHDRAWALS

Adapted from the Maudsley Prescribing Guidelines 2005.

1. Introduction:

The diagnosis and treatment of patients with a history of harmful or hazardous drinking or who present with symptoms of alcohol dependence, is of high importance to prevent alcohol withdrawals.

2. Definition:

The Royal College of Physicians and The Royal College of Psychiatrists classification of drinking:

Safe Drinking per week:	**Males: up to 21 units**	**Females: 14 units**
Hazardous Drinking:	**Males: 21-49 units**	**Females: 14-35 units**
Harmful Drinking:	**Males: >50 units**	**Females: >36 units**

3. Alcohol Withdrawal Symptoms :

Onset : Within hours of the last drink. Peak at 24- 48 hours.
Nausea, vomiting, restlessness, sweating, tremor, anxiety, agitation, insomnia, headache, loss of appetite, tachycardia, hypotension, seizures.

4. SCREENING

4.1 Stage 1

Where harmful of hazardous alcohol intake is suspected but not confirmed the 'Alcohol Use Disorders Identification Test - AUDIT (*Appendix 1)* can be completed. Where a score of over 8 is obtained proceed to stage 2.

4.2 Stage 2

<u>Assessment for Alcohol withdrawals:</u>

- History and assessment of current alcohol use.
  - Consumption over the last 3 months, a typical day's drinking, frequency of drinking, maximum taken in one day, alcohol related physical, emotional and social problems.
- Previous history of alcohol withdrawals and DT's
- Time of most recent drink
- Concomitant drug use
- Severity of withdrawal symptoms
- Co-existing medical / psychiatric disorders
- Physical examination
- Laboratory Investigations: Blood Alcohol Concentration (BAC), FBC, U&E, LFT's, blood glucose, INR, urinary drug screen.
- Pulse rate and B.P. measurement.
  Alcohol Withdrawal scales can be used :

  I. The Clinical Institute Withdrawal Assessment for Alcohol – Revised version: CIWA - Ar (*Appendix 2)* is a useful tool for the clinical quantification of the severity of the alcohol withdrawal syndrome.

  Objective Quantification of alcohol withdrawals: (*Appendix 2)*

Severity of alcohol withdrawals:	**CIWA –Ar score**
Mild	<10
Moderate	10-20
Severe	20+

  II. The Short Alcohol Withdrawal Scale. Self completion questionnaire. Symptoms cover the previous 24 hours. Scores above 12 require pharmacotherapy. (Appendix 3)

5.1 Alcohol Withdrawal Treatment Interventions:

Alcohol Withdrawals	Supportive Care	Medical Care	Pharmacotherapy	Setting
Mild withdrawal symptoms: i.e. irritability, poor concentration, Intake < 50 units per week CIWA – Ar scale <10	Moderate to high level	Little required	Little to none required. Maybe symptomatic treatment i.e. paracetamol, fluids, diet, symptomatic treatment of nausea, vomiting, diarrhoea	Prison
Moderate withdrawal Symptoms: i.e.tachycardia, nausea, tremor, sweats, headache, irritability, flu- like symptoms. Intake > 50 units per week CIWA – Ar scale 10-20	Moderate to high level	Little required	Symptomatic treatment. Substitution treatment of a reducing course of chlordiazepoxide and vitamin supplementation See guidelines	Prison
Severe Withdrawal Symptoms: i.e. Above symptoms**,** Confusion, disorientation, clouding of consciousness, visual, tactile, auditory disturbances, “DTs” CIWA – Ar scale 20+	High Level	Medical monitoring	Symptomatic and substitution treatment required. Refer for inpatient treatment	Hospital
Complicated Withdrawals: i.e. CIWA –Ar > 10 plus medical problems	High Level	Medical Monitoring	Symptomatic and substitution treatment required. Refer for inpatient treatment	Hospital

The dose of benzodiazepine prescribed will depend on the severity of alcohol dependence and the severity of alcohol withdrawals.

5.2 Mild dependence /Mild withdrawals :

Can be managed without medications or small doses of a reducing course of chlordiazepoxide.

5.3 Moderate dependence / Moderate withdrawals :

A typical regime might be Chlordiazepoxide 10-20mg QDS reducing by 20% daily over 5 -7 days.

Day 1	Chlordiazepoxide	20mg qds
Day 2	Chlordiazepoxide	15mg qds
Day 3	Chlordiazepoxide	10 mg qds
Day 4	Chlordiazepoxide	5mg qds
Day 5	Chlordiazepoxide	5mg bd

A PRN dose of 5-10 mg of chlordiazepoxide can be prescribed within the first 24 hours if evidence of alcohol withdrawals and BP > 130 / 90 or PR > 100 bts per min.

BP should be monitored on a daily basis by nursing staff.

If a slower alcohol detoxification programme is required:

- chlordiazepoxide can be reduced by 10% daily
- and / or the rate of reduction could be every 2-3 days.

If there are concerns about adequate dietary intake oral Thiamine (200-300mg daily for 5-7 days) can be prescribed. There is considerable doubt about the usefulness of oral thiamine as it is not adequately absorbed. All patients admitted to hospital for an inpatient detoxification programme should be given parenteral thiamine as prophylaxis for Wernickes's Encephalopathy.

Diazepam:
A typical initial regime is diazepam 5-10mg qds
- reduce on subsequent days by 10 –20% or at a rate depending on symptomatology.

Prophylactic anticonvulsant therapy:
If there is a concern that a patient may be at risk of an alcohol withdrawal seizure then Diazepam may be used as a detoxification regime. In addition anticonvulsant prophylaxis may be added such as Carbamazepine (and in the case of those on methadone Sodium Valproate).

Severe dependence / Severe withdrawals :

Requires larger doses of chlordiazepoxide and inpatient specialist medical care.

Inpatient admission for the medical treatment of alcohol withdrawals in a hospital setting is recommended when:

- There is a history of severe alcohol dependence i.e. persistent use of large amounts of alcohol over a long period of time. (See Symptoms of Alcohol Dependence)
- Severe alcohol withdrawal symptoms
- History of seizures
- History and risk of Delirium Tremens (See symptoms)
- Cognitive Impairment.
- Comatose state
- Associated acute physical illnesses requiring hospital admission
- Poor nutritional state
- Persistent vomiting and dehydration.

<u>Aftercare:</u>

Patients should be encouraged to attend AA and counselling or other aftercare supports on release from prison i.e. residential rehabilitation.

Notes and definitions:

Alcohol Dependence:
If 3 or more of the following have been present together at some time in the previous year.
- A strong desire or sense of compulsion to take alcohol
- Difficulties in controlling alcohol taking behaviour
- Evidence of a withdrawal state
- Evidence of a change in tolerance to alcohol
- Progressive neglect of alternative pleasures or interests. Increased amount of time necessary to obtain or take alcohol or to recover from its effects.
- Persisting with alcohol use despite clear harmful consequences.

Another characteristic feature includes "narrowing of the personal repertoire" i.e. drinking in the same pattern despite social constraints that determine appropriate drinking.

Delirium Tremens :

Impaired consciousness, confusion, disorientation, agitation, tachycardia, hypertension, raised temperature, visual and auditory hallucinations and paranoid ideation

Risk of DT's : History of severe alcohol dependence
Severe alcohol withdrawal symptoms
Older age
History of Delirium Tremens.
Concomitant acute physical illness
Long history of alcohol dependence with previous inpatient treatment.

Hallucinations: Generally respond to chlordiazepoxide and an adequate detoxification regime. If persistent, hallucinations can be treated with an antipsychotic. Some antipsychotics may reduce the seizure threshold and increase the risk of seizures. Advice should be sought from the Drug Treatment Team in the Prison.

Wernicke's Encephalopathy : Ataxia, confusion, Memory disturbance, Hypothermia, Hypotension, Opthalmoplegia / Nystagmus, Coma / Unconsciousness.

Korsakoff's Syndrome: 80% of patients recovering from Wernicke's encephalopathy develop Korsakoff's syndrome: Anterograde and retrograde memory loss, apathy, normal level of consciousness, confabulation.

References:

1. WHO, Audit (Alcohol Use Disorders Identification Test)
2 Sullivan, J.T, Sykora, K,. Schneiderman, J., Naranjo, C.A & Sellers, E.M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA- AR). *British Journal of Addiction,* 84, 1353-1357
3. The South London and Maudsley NHS Trust (2005). Neuropsychiatric conditions in 2005 Prescribing Guidelines, 8th Edition.

Audit (Alcohol Use Disorders Identification Test) *Appendix 1*

1. *How often do you have a drink, containing alcohol?*
(0) Never (1) Monthly or less (2) 2-4 times a month
(3) 2-3 times a week (4) 4 or more times a week

2. *How many units of alcohol do you drink on a typical day, when you are drinking?*
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6
(3) 7, 8 or 9 (4) 10 or more

3. *How often do you have 6 or more units of aclohol on one occasion?*
(0) Never (1) Less than monthly (2) Monthly
(3) Weekly (4) Daily or almost daily

4. *How often during the last year have you found that you were not able to stop drinking once you had started?*
(0) Never (1) Less than monthly (2) Monthly
(3) Weekly (4) Daily or almost daily

5. *How often during the last year have you failed to do what was normally expected from you because of drinking?*
(0) Never (1) Less than monthly (2) Monthly
(3) Weekly (4) Daily or almost daily

6. *How often during the last year have you needed a first drink in the morining to get yourself going after a heavy drinking session?*
(0) Never (1) Less than monthly (2) Monthly
(3) Weekly (4) Daily or almost daily

7. *How often during the last year have you had a feeling of guilt or remorse after drinking?*
(0) Never (1) Less than monthly (2) Monthly
(3) Weekly (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly
(3) Weekly (4) Daily or almost daily

9. *Have you or someone else been injured as a result of your drinking?*
(0) No (2) Yes, but not in the last year
(4) Yes, during the last year

10. *Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?*
(0) No (2) Yes, but not in the last year
(4) Yes, during the last year

RECORD TOTAL OF SPECIFIC ITEMS HERE

If total over 8, alcohol disorder very likely

This questionnaire wwas developed by the World Health Organisation to identify persons whose Alcohol consumption has become hazardous or harmful to their health.

Appendix 2

Clinical Institute Withdrawal Assessment of Alcohol Scale CIWA- **AR**

Patient Name:_________________________ ______ Date____________ Time_____________

Pulse or Heart rate, taken for 1 minute____________________ Blood Pressure______________

NAUSEA AND VOMITING- Ask “Do you feel sick to your Stomach? Have you vomited?” Observation.

0 No nausea and no vomiting
1
2
3
4 Intermittent nausea with dry heaves
5
6
7 Constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES – Ask “Have you any itching, pins & needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?” Observation

0 None
1 Very mild itching, pins & needles, burning or numbness
2 Mild itching, pins & needles, burning or numbness
3 Moderate itching, pins and needles, burning or numbness
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

TREMOR- Arms extended and fingers spread apart. Observation

0 No tremor
1 Not visible, but can be felt fingertip to fingertip
2
3
4 Moderate, with patient’s arms extended
5
6
7 Severe, even with arms not extended.

AUDITORY DISTURBANCES – Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things that you know are not there?” Observation

0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability to frighten
3 Moderate harshness or ability to frighten
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

PAROXYSMAL SWEATS – Observation

0 No sweat visible
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

VISUAL DISTURBANCES – Ask “Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing any thing that is disturbing you? Are you seeing things that you know are not there?” Observation

0 Not present
1 Very mild sensitivity
2 Mild sensitivity
3 Moderate sensitivity
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

Anxiety – Ask “Do you feel nervous?” Observation.

0 No anxiety, at ease
1 Mild anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD – Ask “Does your head feel different? Does it feel like there is a band around your head? “ Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 No present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

AGITATION – Observation

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM – Ask “ What day is this? Where are you? Who am I?”

0 Oriented and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disorientated for date by no more than 2 calendar days
3 Disorientated for date by more than 2 calander days
4 Disorientated for place/or person.

Patients scoring <10 do Not usually need additional Medication for withdrawal

Total CIWA- Ar Score ________

Rater’s Initials _______

Maximum possible score 67

Quantification of Alcohol Withdrawals

Severity of Alcohol Withdrawals:	CIWA-Ar Score
Mild	<10
Moderate	10-20
Severe	20+

Appendix 3.

The Short Alcohol Withdrawal Scale (SAWS)

Short Alcohol Withdrawal Scale	None (0)	Mild (1)	Moderate (2)	Severe (3)
Anxious				
Sleep Disturbance				
Problems with memory				
Nausea				
Restlessness				
Tremor				
Feeling Confused				
Sweating				
Miserable				
Heart Pounding				

Symptoms cover the previous 24 hour period. Scores above 12 require pharmacotherapy.

19. COCAINE TREATMENT POLICY

The interdisciplinary team provides treatment for cocaine abuse on an individual basis, at all locations as required. Primary cocaine users will be offered a range of treatments, including counselling treatment provided by counsellors, using evidence based approaches (e.g. CBT).

Appropriate referrals are made for medical and psychiatric issues, which may arise from cocaine use.

- Withdrawal from cocaine use can increase the patient's risk of depression and suicidal behaviour.
- All cocaine positive urines will be discussed with patients. Early intervention may prevent a serious problem developing.
- The doctor and care team has a full discussion with the patient around route of administration i.e. snorting, injecting, smoking (freebasing and crack)
- The doctor and care team discuss with patient harm reduction measures i.e. use of clean needles and non-sharing of drug using paraphernalia, link with HIV transmission and increased risk of sexually transmitted diseases (STD's) because of unsafe and uninhibited sexual activity. Patients are also made aware of the increased risk of medical complications e.g. DVT.
- Persistent use requires more in-depth counselling. In the absence of reliable and evidence based pharmacotherapeutic interventions, our service is concentrating on evidence based psychotherapeutic interventions as appropriate.
- Special cocaine education/prevention groups will be set up on a needs basis in prison settings.
- Clinical teams will continue the development and implementation of a cocaine awareness strategy.
- The IPS will continue to monitor the cocaine problem and expand services to this patient group as required.

20. PSYCHIATRIC ASSESSMENT OF SUBSTANCE MISUSE DISORDERS

It is the policy of the IPS, in accordance with the community standard, to develop a dual diagnosis service for those patients requiring same in the prison service.

Appendix 5 – Psychiatric Assessment of Substance Misuse Disorders
Appendix 6 – Current Processes in the Medical Unit Involving Patients on a Methadone Maintenance Programme

21. THE ASSESSMENT AND TREATMENT OF PREGNANT PATIENTS

INTRODUCTION

Pregnancy may motivate women using drugs to change their lifestyle and engage services. Equally, being committed to prison at this time may afford them the opportunity to reflect on issues affecting their health and that of their unborn child.

Since both mother and child are affected by the drug-taking lifestyle, this makes it all the more imperative that high-risk activities be avoided such as i.v drug use with exposure to HIV/viral hepatitis.

OBJECTIVES OF CARE

- The stabilisation of mother's drug use
- Retention of mother in obstetric and drug treatment service and ensuring adequate support and throughcare in the community.
- To deliver a full-term baby with healthy birth weight
- Avoidance of in utero exposure to HIV/hepatitis
- Minimisation of the occurrence of neonatal abstinence syndrome
- Promote and support positive physical, mental health and social wellbeing though out and after pregnancy.

ASSESSMENT

Nursing – Usual assessment with attention to present pregnancy history, past ob/gyn history and drug history.
GP Assessment – Usual assessment with attention on examination to fundal height (? Consistent with EGA) and FHR.

Methadone stabilisation and maintenance are the treatment of choice in pregnant opiate-dependent women.

Refer to IPS Methadone Treatment Guidelines.

1. Patient already on methadone maintenance treatment – continue and consult Drug Liaison Midwife and Drug Treatment Clinic with respect to dosage changes.
2. Patient not on methadone treatment – contact GP Co-ordinator or Consultant Psychiatrist in Addiction for clinic in her area and the Drug Liaison Midwife for the hospital where she will deliver.

TREATMENT

Drug Liaison Midwife

Co-ordinates care for the pregnant, opiate-addicted woman – liaises between maternity hospital, GP, Drug Treatment Centre and social services in the antenatal period.
Linking with the Midwife on all matters to do with the pregnant women's treatment is recommended especially including destabilisation and methadone dosage changes.
Contact Rotunda, Coombe or Holles St. – for details of liaison midwives.

Detoxification

In the exceptional circumstance where detoxification is being considered then it should be done in the second trimester and with close liaison with the drug treatment and obstetric services.

Dose Reduction

Dose reduction is not recommended in the first (due to the risk of spontaneous miscarriage) or third trimester (due to the risk of preterm labour) and indeed occasionally patients may need a slight increase in dose at this time (due to the expanded blood volume).

BDZ's

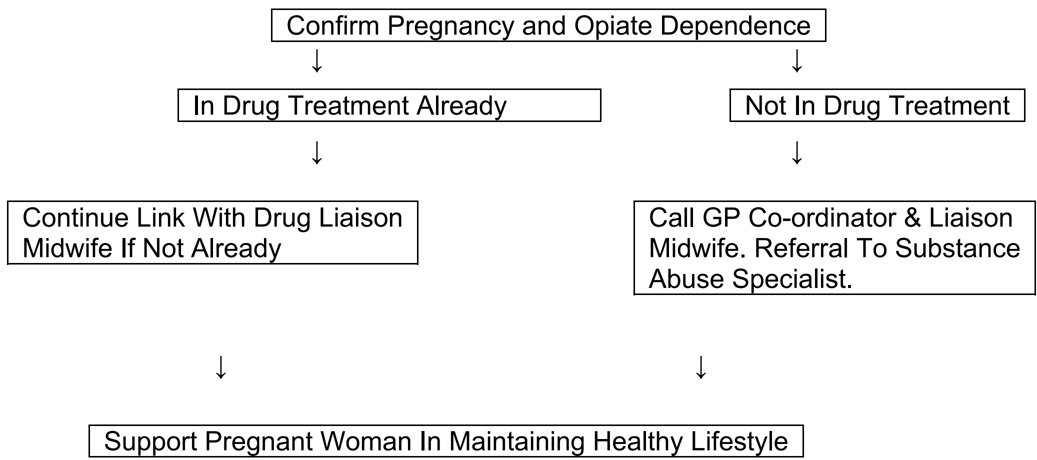
BDZ detoxification should be prescribed as per usual clinical protocol.

Other psychotropics

The clinical decision to continue medication should be made on reviewing the risk/benefit and specialist psychiatric and obstetric opinion may be required.

Emergency Treatment

The initiation of methadone should be done in consultation with the drug treatment services and Drug Liaison Midwife. If the assessing clinician is in any way dissatisfied with the assessment, a specialist addiction clinician should carry out a further assessment. Pregnant women are given priority access to community services.
The Midwife, prison GP and GP Co-ordinator should liaise to identify the most appropriate treatment location for the patient.


Confirm Pregnancy and Opiate Dependence
In Drug Treatment Already
Not In Drug Treatment
Continue Link With Drug Liaison Midwife If Not Already
Call GP Co-ordinator & Liaison Midwife. Referral To Substance Abuse Specialist.
Support Pregnant Woman In Maintaining Healthy Lifestyle

22. USE OF NUTRITIONAL SUPPLEMENTS

INTRODUCTION

While severe, clinically-apparent nutritional problems are rare, subtle nutritional deficiencies are common in the prison population. These range from poor intake of fresh fruit and vegetables to drastically reduced intake of all types of food. The drug-taking lifestyle is associated with anorexia which, combined with chronic viral disease, skin and lung infections can result in severe malnourishment.

ASSESSMENT

As well as the usual nursing and GP assessment, a patient suspected of having a nutritional deficiency should have a careful food and weight history taken. On examination weight should be noted (usually recorded on committal) along with signs of anaemia, easy bruising, lanugo hair, lack of muscle mass, striae from weight loss etc. Occasionally blood tests may be indicated as part of assessment.

NUTRITIONAL SUPPLEMENTS

These include high calorie meal replacements such as "Ensure" or those marketed to help chronic skin ulcer healing. Also considered are individual vitamin and mineral supplements such as Thiamine, Folic Acid, Vitamin C, Iron and Multivitamin Tablets.

NUTRITIONAL SUPPLEMENTS AND PRISON

Some points to be noted with regard to nutritional supplement use in prison:

- High-calorie supplements are almost never indicated in patients who have an intact gastro-intestinal tract.
- Patients who are underweight and undernourished have poor appetite secondary to their lifestyle: the use of a high calorie supplement will only dull their appetite even more for fresh food which they do start eating as their chaotic habits are replaced by prison routine.
- Prescription of high calorie supplements again encourages the 'quick-fix' culture/mentality which characterises drug addiction and fails to address the longer term psycho-social issues which have resulted in poor nutrition.
- "Ensure" and other high calorie supplements have currency and are traded for cigarettes, drugs etc.
- Occasional male patients develop an obsession with body-building and may request high calorie supplements if they perceive them as an aid to muscle/weight gain.
- Severe chronic alcoholics should be routinely supplemented with Thiamine.
- Folic acid supplementation is recommended for women at risk of pregnancy.
- Iron deficiency is common in the female prison population.
- Nutritional supplements prescribed from another source should be reviewed by the prison doctor before being prescribed.

MEDICAL ROLE IN NUTRITION

The nursing and GP role is to encourage the patient to eat a regular, balanced and healthy diet and also to take an appropriate amount of exercise. Psycho-social aspects of nutritional problems, such as lack of education and depression should also be addressed using available services.

Policy

- High calorie supplements should almost never be prescribed in the prison setting.
- Individual vitamins/minerals should be prescribed as suggested above: care should be taken when prescribing multivitamins not to cause overdosage e.g. hypervitaminosis A.

23. NICOTINE REPLACEMENT THERAPY

It is IPS policy to provide smoking Cessation Treatment in line with what is provided under the GMS.

HC Policy C/4

NICOTINE REPLACEMENT THERAPY

Treatments available under the GMS, including Nicotine Replacement Therapy (NRT), are made available to prisoners subject to clinical considerations. Given the very high prevalence of smoking among prisoners we would seek to assist anyone genuinely motivated to give up cigarettes in any way possible. Giving up cigarettes requires more than replacement therapy alone and the evidence is that combined approaches are more successful than single focussed ones. In this context NRT prescription is fully justified in those indicating serious motivation, including active participation in any associated counselling programme. Where such motivation is lacking a more cautious approach to prescribing NRT is recommended.
Any decision to supply such therapy from within the prison healthcare budget should take this into account.

Appendix 13 – Use of Nicotine Replacement Therapy

24. CHILD PROTECTION

It is the policy of the IPS to provide a copy of "Children First (Summary)" to all of their staff working in prisons. It is recommended that all staff receive training on 'Children First.

It is the responsibility of all agencies working within prisons to follow local and national guidelines in relation to the reporting of child abuse.

It is the responsibility of staff to act quickly in relation to any child abuse concern and to keep accurate notes.

In order to support children and families it is appropriate for agencies to adopt an effective, co-ordinated and joint working approach.

Families affected by substance misuse will not be considered at risk of harm by virtue of the sole fact that their carer is a substance misuser.

In relation to the Dóchas Centre, in some circumstances, there may be pre-birth risks and concerns which will require reporting and assessment.

Children may be at risk from other forms of unacceptable behaviour (physical, sexual, emotional and neglect) which will require action under these guidelines.

Reports should be made to the HSE if there are reasonable grounds for concern that any child may have been abused, or is being abused, or is at risk of being abused.

The retrospective disclosure of child abuse from any one, no matter how old, may have implications, in terms of risk, for other children and these disclosures must be reported. There are supportive services for victims making disclosures and they should be encouraged to contact, where possible, HSE services, An Garda Siochana or counselling services such as Laragh.

Appendix 8 - 'Children First'

25. MONITORING AND EVALUATION

- It is the policy of the IPS to carry out evaluation and audit of treatment interventions on a regular basis, and to modify practice on the results of such audit and evaluation.

- It is the policy of the IPS to audit the implementation of policy.

26. LIAISON AND TRANSFER ARRANGEMENTS BETWEEN COMMUNITY AND PRISON DRUG TREATMENT SERVICES

Contents

Introduction

1. Patients on methadone on admission to prison/community services

   Confidentiality
   Confirmation of treatment
   Process
   Written confirmation
   Contact details

2. Initiating treatment in prison

3. Reporting to CTL

4. Guidance on handling of patient's methadone supply

5. Treatment Planning for Release from prison

   Planned release
   Protocol for patients who, prior to admission to prison, had been treated in DTC
   Protocol for patients who, prior to admission to prison, had been treated in satellite clinic, community pharmacy or from community G.P.
   Protocol if unable to contact G.P. / Chief Pharmacist above
   Unplanned release
   Audit Report of Unplanned Arrival at Community Services

6. Patients released over Christmas/New Year

Introduction

The Irish Prison Service in partnership with the HSE has a responsibility to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the HSE. This means that both prisons and the community services should provide health education, patient education, prevention and other health promotion interventions within that general context.

Issues Unique to Providing Methadone Treatment in Prison:

Effective and efficient communication between both the IPS and the HSE is essential to ensure seamless care and safe and effective treatment for our patients.

The following protocols have been developed to assist in ensuring safe, timely and appropriate transfer of patient information from one service to the other.

1. Patients on Methadone Treatment on admission

1.1. Confidentiality

Patient confidentiality must be adhered to at all time by all doctors/pharmacy staff/ prison health care staff members. (See Confidentiality Policy – Pg 37)

Confirmation of treatment:

To ensure that patient confidentiality is adhered to at all times, it must be confirmed that the individual requesting the information is from another institution i.e. prison, HSE or hospital where it can be confirmed that the query is genuine.

To ensure the safe continuation of Methadone and/or medical treatment for patients transferring between community and prison drug treatment services, it is essential that verbal and written confirmation of the patient's current Methadone and/or medication prescription is obtained before a new prescription is written or the next dose of methadone/medicines is administered.

1.2.1 Verbal Confirmation

When requesting patient details and providing patient information:

a) Contact the relevant service provider, provide your name and where you are calling from (Prison , Drug Treatment Centres/Satellite, Community pharmacists and hospital ward-if relevant) and your status e.g. nurse or medical orderly, doctor, pharmacist etc.
b) Provide the patient's details: Name and D.O.B.
c) Confirm dose and date last dispensed (direct person to person contact)
d) Provide / Receive written details of patient history, treatment, and medications.

1.2.2 Written confirmation

The verbal confirmation of patient's medications information must <u>be verified by fax</u> to the requesting service, by means of the "**PRISON/COMMUNITY TRANSFER OF INFORMATION"** form (**Appendix 6**) which must be completed and faxed to the requesting service.

1.2.3 Lists for numbers of Drug Treatment Centres/ Satellite Clinics/Prison surgeries.

The contact details for each clinic are included in **Appendix 7**.

The prison surgery details are included in **Appendix 8**.

2. Initiating Treatment in Prison

Treatment may only be initiated in prison when confirmation of available places in the community is established.

Before initiating methadone treatment in prison the prescribing doctor must communicate with the relevant personnel in the community (GP Co-ordinators, Consultant Psychiatrists and Chief Pharmacists in DTC and Satellite clinics).
Written confirmation of such arrangement must be communicated by the prescribing doctor involved to relevant personnel in both the HSE and IPS and such confirmation must be retained as per local policy (**Appendix 9**).

The issue of validation of address and suitability for community treatment need to be given consideration by the prescribing doctor before initiating treatment.

3. Reporting to the Central Treatment List (CTL)

To ensure accurate timely data input in the CTL for the purposes of audit and strategic planning of services:

- The CTL requires the prescribing doctor to submit to the CTL a patient treatment form for each patient admitted to prison/community services who will be provided with Methadone Treatment in that service (entry form) and when patients are released from the Prison/discharged from the community services (exit form). (**See Appendix 10**).
- It is also necessary that if patients transfer within the prison services that the CTL is informed via the appropriate documentation.

On committal to prison -

IPS:

- The prescribing doctor in the prison must send an entry form to the CTL (**Appendix 10**) and inform them that the patient has been admitted to prison.

HSE:

- The prescribing doctor in the community must also send an exit form to the CTL to inform them that the patient has been discharged from the community service.
- On release from prison back to the community a similar process applies in reverse.

IPS Staff see Chapter 5 in this document. HSE staff see document prepared by Nihal Zayed.

In cases of intermittent sentencing or in very short sentences (less than 30 days) other procedures may be more practical.

Central Treatment List Fax no: 01 – 6771519

4. Methadone brought into prison with a patient

Methadone accompanying any patient on committal to prison should be discarded as per IPS Healthcare Policy A/20 and A/23 (or **Appendix 3** in this document.

The relevant dispensing service in the community should be informed of the destruction of methadone.

5. Treatment Planning for Release

One of two scenarios is usually encountered in this setting:

- **release date known - planned release**
- **release date unknown or unexpected – unplanned release**

5.1 Planned release

When the release date of the patient is known arrangements should therefore be made in advance by the prison healthcare staff.

5.1.1 Protocol for Patients who had, prior to committal to prison, been receiving their treatment in a <u>Drug Treatment Centre (DTC):</u>

- Contact the prescribing doctor/Chief Pharmacist in that setting (DTC)
- On Saturday/Sunday, contact the Pharmacist on the direct pharmacy number in each clinic.

5.1.2: Protocol for patients who had, prior to committal, been receiving treatment in a Satellite Clinic or Community Pharmacy or from Community GP

Contact the GP Co-ordinator/Chief Pharmacist who will arrange a suitable delivery of service in the nearest DTC until appropriate arrangements are made. In this case, an entry form should be submitted by the prescribing doctor/Chief Pharmacist.

5.1.3: If it is not possible to contact the GP/Chief Pharmacist the patient should be directed to the nearest DTC in their area.

If the patient has been in the prison for a short period (30 days) his/her name will be still on the methadone prescription list (HSE Policy).

5.2: Unplanned release - release date unknown or unexpected

Patients are often released from custody directly from Court without the knowledge of the prison or may be released in advance of planned release date due to necessary operational decisions.
Therefore:
• the patient should always be dispensed his/her Methadone in the prison on the day of release/court attendance. It remains best practice however for the HSE service provider to check the last dose dispensed on the day of a Court appearance/release, to avoid any possibility of double-dosing/overdose.

There is a responsibility on prison management to inform healthcare staff of all discharges and transfers on a daily basis to facilitate healthcare staff preparing discharge summaries.

Once prison healthcare staff are aware (i.e. their own dispensing records or through prison management) of discharge or transfer of patients appropriate information needs to be completed and forwarded to the relevant treatment agency in the community.

5.3: Audit Report of Unplanned Arrival at Community Services

In the event that a patient arrives unannounced to a community service provider (DTC/Satellite clinic/Community Pharmacy/GP) an Audit Report (**Appendix 12**) must be completed by the Pharmacist and returned to the Co-ordinator of Drug Treatment Services (Prisons), Chief Pharmacist HSE and Co-ordinator of Pharmacy Services IPS. This will assist the IPS in putting in place appropriate arrangements/structures to ensure effective communication and safe continuity of treatment for all patients requiring Methadone Treatment, on release from prison. As part of the audit process these reports will be reviewed by both HSE and IPS and changes made to procedure accordingly.

Once healthcare staff become aware that a patient has been released or transferred they should ensure that the relevant information is communicated.

6. Patients released over Christmas/New Year

Arrangements have been agreed between the HSE/IPS for the safe continuation of Methadone treatment for those patients granted temporary release (TR) over the Christmas/New Year periods. See Joint HSE/IPS Policy (**Appendix 11**)

The Co-ordinator of Pharmacy Services, IPS emails the details of such patients to the Chief Pharmacists in each area.

The List includes the following
- Name of service users
- Date and duration of the release
- Dose of methadone dispensed in the Prison
- Strength and name of other medication received in Prison

Arrangements are made by the Chief Pharmacist/ GP Co-ordinator/Consultant Psychiatrist in each area for the allocation of places and provision of services to facilitate such patients on TR.
The signed methadone / medication prescription will be sent to the allocated settings from the GP Coordinator and in each setting the pharmacist or nurse will be phoned to make sure they have received the prescriptions to ensure smooth operation over this period. It is the pharmacists/clinical teams responsibility to give a list of the patients released over this period to the senior General Assistant (GA) in each setting to communicate the information to his/her staff.
Allocation of a treatment site for TR does not guarantee treatment at that location for subsequent treatment events.

Direct person to person contact is necessary to validate treatment details.

Appendix 9 - Prison/Community Transfer of Information Form
Appendix 10 - HSE Contact details
Appendix 11 - IPS surgery contact details
Appendix 12 – Application for a Community Treatment Place
Appendix 13 - CTL entry/exit form
Appendix 14 - Joint HSE/IPS Christmas release arrangements
Appendix 15 - Audit Report of Unplanned Arrival at Community Services

APPENDICES

Appendix 1 – Consent Documents
Appendix 2 - Urine Screening Procedure
Appendix 3 – Use of Methadone Processes
Appendix 4 – Disposal of Methadone
Appendix 5 – Psychiatric Assessment of Substance Misuse Disorders
Appendix 6 – Current Processes in the Medical Unit involving Patients on a Methadone Maintenance Programme
Appendix 7 – Use of Nicotine Replacement Therapy
Appendix 8 – 'Children First'
Appendix 9 – Prison/Community Transfer of Information Form
Appendix 10 – HSE Service Provider (DTC/Satellite) Contact Details
Appendix 11 – IPS Surgery Contact Details
Appendix 12 – Application for a Community Treatment Place
Appendix 13 – CTL Entry/Exit Form
Appendix 14 – Joint IPS/HSE Arrangements for the Supply of Methadone to Patients on Christmas/New Year Temporary Release
Appendix 15 – Audit Report of Unplanned Arrival at Community Services

APPENDIX 1

CONSENT DOCUMENTS

Consent Forms

I ___________________________________ consent to the following:

Assessment:

	Consent to consent	Refusal
	☐	☐

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

Treatment:

	Consent to consent	Refusal
Methadone Substitution Programmes		
1. Stabilisation / Maintenance Programme	☐	☐
2. Stabilisation / detoxification Programme	☐	☐
3. Detoxification Programme	☐	☐
Other Substitute Programmes		
Name:	☐	☐

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

Other Treatments

	Consent	Refusal to consent
Counselling	☐	☐
Lofexidine treatment	☐	☐
Naltrexone treatment	☐	☐
Referral to other agencies as appropriate	☐	☐

Consent to interdisciplinary sharing of clinical information with the clinical interdisciplinary team:

☐ ☐

The team can include the following:

- Doctor
- Nurse
- Counsellor
- Psychiatrist
- Pharmacist
- Psychologist

SIGNED: ________________________ **DATE:** ____________

WITNESS: ________________________ **DATE:** ____________

Lofexidine – Consent to Use Unlicensed Treatment

I consent to a lofexidine detox programme and I understand that it is an unlicensed medicine and provided on a named patient basis only

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

Release of Information

I consent for the release of information to the following agencies:

	Consent	Refusal to consent
	☐	☐

____

____

____

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

Withdrawal of Consent

I withdraw my consent to the following:
____

____

____

on (date) ______________________ for the following reasons: ___________

____

____

SIGNED: _________________________ **DATE:** _____________

WITNESS: _________________________ **DATE:** _____________

HEPATITIS B, HEPATITIS C & H.I.V. PRE-TEST DISCUSSION

I ________________ have engaged in a pre-test discussion with __________
Covering the following areas:

- An explanation about the blood tests for Hepatitis C & H.I.V.
- The meaning of a positive test result and the meaning of a negative test result.
- Risk factors: - safer sexual practices
  - safer use of all drug-using equipment (needles, syringes, filters, tooters etc)
  - importance of not sharing razors, toothbrushes, earrings etc.
  - the risks to my health if I drink alcohol.
- Support that is currently fully available to me from other people (family, partner, friends, professional support)
- Insurance and mortgage implications.
- Harm to self and harm to others
- Explanation of the 'window period'.

I fully understand the above discussion and explanations.

Signed:________________ Witnessed: ______________ Date:__________

I consent to have a H.I.V. test: Yes: __________ No: ___________

Signed:________________ Witnessed: ______________ Date:__________

I consent to have a Hepatitis B test: Yes: _________ No: __________

Signed:________________ Witnessed:______________ Date:__________

I consent to have a Hepatitis C test and PCR Test if required:
Yes: _____ No: ______

Signed:_______________ Witnessed: ______________ Date:__________

I consent to have the following vaccinations and repeat antibody checks as appropriate:

		Yes	No
Day 1	Twinrix (Smith Beecham) against Hep A & B	____	____
One month	Engerix B (SKB), Hepatitis B alone	____	____
5 months later	Twinrix (SKB)	____	____
6 weeks later	Antibody levels for Hepatitis B	____	____
1 year from start	Booster for Hepatitis A (Haverix, SKB)	____	____

Signed:________________ Witnessed: _____________ Date:__________

I _________________________ have held a Hepatitis B, Hepatitis C, & H.I.V. pre-test discussion with the above client, explaining the issues as mentioned above and am satisfied that the client fully understands the content of the discussion.

Signed: ____________________________ Date: _________________

Information Sheet

Record Keeping

1. This information sheet is designed to give you an understanding of:
- What happens to the information you give us?
- Who has access to this information?

2. The information you give us is used to provide you with healthcare and related services. We need a full social, psychological and medical history to make a proper assessment of your needs and to decide with you an appropriate treatment plan. The information system is used to record the treatment and advice you will receive. It will also be used for administrative purposes and to meet legal requirements in relation to the services we provide. The information you give us is held on computer and/or paper.

3. The information whether on computer or paper is normally only seen by staff member. Staff members are members of the clinical interdisciplinary team.

4. Some information will be sent with your blood or urine tests, this is so the laboratories know which client the test is from and to make sure it is correctly tested. You will be informed of all tests that will be performed.

5. Information about you will not normally be released to others without your written consent. There are occasions when information may be released without your consent e.g.
- When ordered by a court of law or a tribunal
- When allowed or required by statute
- When necessary to protect your interests
- When there is a substantial and immediate risk to the welfare of yourself or (an)other /individual(s).

6. In addition some information may be used for statistical or research purposes, but the information used will not identify you in any way.

7. You have the right to information about your treatment. If you have any queries please ask.

I have read the information sheet and have been given a copy to keep. I have had a chance to ask questions about the information, which is collected and kept about me, why it is kept and how it is used or disclosed. I understand that the information is held on computer and/or paper. I consent to this to the purposes for which the information is being collected, kept, used, and disclosed.

The above information has been explained to me ☐

Name of staff member who gave the information and explanation:

____

SIGNED: _________________________ **DATE:** _____________

WITNESS: _________________________ **DATE:** _____________

Central Treatment List

	Consent	Refusal to consent
I consent to place my name with the Central Treatment List	☐	☐

SIGNED: ______________________ **DATE:** ____________

WITNESS: ______________________ **DATE:** ____________

Pompidou Forms

Your Pompidou form will be completed annually.

SIGNED: ______________________ **DATE:** ____________

WITNESS: ______________________ **DATE:** ____________

Methadone Information

1. This is to certify that I have been opiate dependent (that is I have an opiate addiction). I have requested to commence a methadone substitute programme.

2. I understand that like any other medication methadone has side effects. In particular I understand the risks of overdose and death (in certain cases), if I inject or use other opiates, including extra methadone, excessive amounts of alcohol, benzodiazepines and other sedative drugs 'on top of' my methadone.

3. I also understand that I need to store any take home methadone in its proper childproof container and to store the bottle out of reach of children (relevant when released from prison).

4. I understand that methadone itself does not cure the underlying drug dependency and may be even more difficult than heroin or morphine to detoxify from and if taken by those who are not dependant can create opiate dependency. Rarer side effects such as reduced adrenaline excretion by the adrenals has been reported, as have allergic reactions. A small proportion of males have experienced an anti-testosterone effect with methadone maintenance.

5. If I become pregnant and am unable to detoxify then my baby will be exposed to opiates up to and including the time of birth. This may cause neonatal abstinence in the baby, (a form of withdrawal state), after birth.

6. It is important to remember that your methadone has its peak effect 2-4 hours after taking it. Methadone will accumulate in your body over time and will have a greater effect on you in day 3-5 of starting treatment.

7. Only patients who are stable on methadone would be safe to drive a car or operate machinery. However those who are abusing cannabis or alcohol or other illicit or psychotropic medication would be considered unsafe to drive. Certain patients who are stable, for example, on benzodiazepines prescription on a long-term basis may be considered safe to drive a car. You will need to discuss this with you prescribing doctor and you are strongly advised to take their advice.

8. The potential benefit of methadone is that it gives me an opportunity to stabilise my drug addiction and lifestyle. Weighing all of the risk and potential benefits I have decided that I wish to be placed on methadone substitute as the best approach to my current addiction. All of the above has been explained to me and I agree to commence methadone substitute treatment.

SIGNED: ___________________________ **DATE:** _____________

WITNESS: ___________________________ **DATE:** _____________

Rules and Contract

We welcome you to the Prison Drug Treatment Service for treatment of your drug problems. We wish to provide you treatment in a professional and friendly environment. To assist us in running the Prison Drug Treatment Service in a friendly, smooth and safe manner, we ask you to abide by the following rules:

1. I agree to participate fully with the treatment programme offered to me and, when required, keep appointments with the doctors, counsellors, pharmacy, nurse and any other persons who are involved in my treatment.
2. I agree to stabilise my drug use while on treatment
3. I agree that verbal or physical aggression towards staff or other clients may lead to a sanction. It is not permitted to possess or produce any instrument that can be used as a weapon while in treatment.
4. I agree to attend daily for methadone, which will be taken under supervision between ______ and _________. Failure to attend for two or more days will result in receiving half doses for safety reasons.
5. I agree to give a urine specimen as requested. Small amounts of urine are not accepted. In the event I'm unable to supply a specimen I understand I will be allowed 15 minutes to produce a specimen. If I fail to produce a specimen it will count as a refusal and will be documented as a refusal. The provision of a false urine sample will be documented and discussed with your doctor / clinical interdisciplinary team
6. I may be asked to be breathalised by a member of staff/pharmacy at anytime. If I have a level of alcohol above a certain limit I may have to have the methadone reduced or not dispensed that day.
7. I accept that if I give persistently positive urines for opiates or other drugs, or that I do not comply with the conditions of treatment, that my methadone treatment will need to be reviewed and options include:
   - A reduction in my dose
   - Placement on a low dose programme
   - A change of treatment programme
   - A recommendation to the Governor requesting transfer from the Medical Unit
8. I have received a list of drugs which are not allowed and understand it is my responsibility to check out every drug with a member of staff before I take it, not after.
9. Letters for courts will only be given upon written request from a solicitor or probation officer. A minimum of two weeks notice is necessary for receipt of a letter.

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

Specific Programmes:

F6: A separate contract needs to be signed with the Governor. A failure to comply with this contract may lead to the Governor referring to the Clinical Interdisciplinary Team for assessment.

F3 + F4: I accept that if I give a positive urine for opiates or other drugs, or that I do not comply with the conditions of treatment, that my methadone treatment will be reviewed and a warning and a date to clear given. Subsequent positive urines will be subject to a disciplinary report to the Governor resulting in a transfer out of F3 or F4.

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

F5; Drug Treatment / Detoxification Programme

In addition to the above contract:

1. I fully accept that Occupational, recreational and Group Therapy are part of the treatment programme and that my participation is compulsory in the follow-up group in the Training Unit for the first three weeks there.
2. I agree not to request temporary release while I am on this programme.
3. I agree to contact being made with my family or significant others to inform them about the programme and to offer them support meetings during the programme.
4. Participants will agree to visits at specific times and only specific people will be permitted to visit. Participants can have two visits per week from either two adults or one adult and their own children. Visiting times are Thursday 2.00pm to 4.00pm and Saturday 10.00am to 12.00pm and 2.00pm to 4.00pm. The names of these visitors will be given at the start of the programme and must be the only visitors during the programme.

    a. Each visit will last for 30 minutes
    b. No physical contact is permitted during visits
    c. No smoking during visits
    d. No packages or money may pass from visitor to client
    e. No visits from family in prison or from drug users

SIGNED: __________________________ **DATE:** _____________

WITNESS: __________________________ **DATE:** _____________

Responsibilities of the Healthcare Staff:

Is to provide:

- A structured methadone treatment programme
- Team confidentiality
- Professional behaviour and respect from the staff
- Medical advice and attention
- Counselling
- Viral screening
- Rehabilitation/Integration options

We agree that all staff treat you in professional manner with dignity and respect at all times.

We agree to be available to you for consultation around your treatment and any other issues we can deal with ourselves or with referrals to other agencies.

We agree that a complaints procedure be available to you to pursue issues around your treatment, with the assistance of a member of staff if needed.

Please refer to the patients' charter which will make you aware of your rights.

I agree to abide by the above rules and understand that it is my responsibility to do so. I have received a copy of the rules and understand that any difficulty I may have in respect of the above can be discussed with a member of staff of my choosing and the same will be given due attention.

This contract has been read to by ______________________/by me and

signed by me ______________________ Date __________________

Witnessed _________________________ Date __________________

We refer you to patients of charter of rights as a document to make your more aware of your rights.

APPENDIX 2

URINE SCREENING PROCEDURE

(Policy 8: Toxicology Screening of Urine)

Basic Principles

- The taking of urine is not a medical procedure and as such does not require trained medical staff to carry out the process. Best practice would dictate that an **explicit contract** be signed by the client agreeing to the process, after the rationale had been fully explained. Confirmation of the name and date of birth confirmed between the patient and the staff member supervising the process. In the case of on site testing the patient where possible should witness the process, initial the sample and be made aware of the results.

- It is established best practice in Ireland that same sex supervision take place, i.e. It is inappropriate for male members of staff to supervise female urine screening patients and likewise female members of staff to supervise males.

- The dignity of the patient must be maintained at all times. Personnel taking urine sample must be gender appropriate to the patient whose urine sample is being taken.

- Protective gloves must be worn during the procedure in the interest of hygiene and safety (universal precautions).

- A properly labeled bottle must be used, the details on the label should be shown and checked with the patient. This practice can save argument at a later date re; ‘wrong person’ ‘wrong bottle’ ‘wrong date’ etc.

- The patient should be directly observed giving the sample either through the aid of a mirror or by close supervision. Mirrors are probably a better option, as close supervision can be intimidating. The officer should observe for paraphernalia that may indicate the intention to give a false sample, small tubing, Lemon Jiff bottles etc.

- The specimen bottle should be at least half full. When the lid is secured on the sample a small condensation line should appear for a few seconds, this would normally indicate the sample is of body temperature.

- Specimen bottles should be packaged for transport in line with current best practice guidelines, i.e. shatter proof containers, clearly labeled, lids tightly secured etc, and transported in accordance with current legislation.

- Packaging and dispatch of samples should comply with the Carriage of Dangerous Goods by Road Regulations 2001.

- Labeling of samples must comply with labeling policy as outlined in the contract with Claymon Labs, as follows:

  “The sample container should then be closed tightly and a tamper evident seal placed across the lid and down either side of the specimen container. The patient should place their initials on the seal, for authentication purposed. If the patient merely makes their mark on the seal, the Officer should authenticate this mark with their own initials. N.B. It is the responsibility of the collecting Officer to ensure that the specimen lid has been secured prior to placement of the tamper-evident seal.”

APPENDIX 3

USE OF METHADONE PROCESSESS

(Policy 9: Use of Methadone – Ordering, Dispensing, Administration & Recording)

1. ORDERING PROCESS:

a). Ordering:

- A book of pre-printed requisition forms is available in each surgery, in duplicate form.
- A new requisition form must be used for each order. This may be completed by a healthcare staff member but must be signed by a doctor.
- The completed and signed requisition is then sent to the stores department, where it is assigned an order number and is then faxed to the supplier.

b). Receipt of Supplies:

- Ideally any supplies of methadone should then be delivered to the doctor and the delivery note signed by the doctor. This task can however be delegated by the doctor to another healthcare staff member, who has been named as an authorised messenger and who can accept delivery on behalf of the doctor.
- The order will then be delivered directly to the surgery areas, as per agreed local arrangements.
- The delivery will then be accepted by an authorised member of the healthcare staff who will be required to sign the delivery note and return the top copy to the delivery person.
- A copy must also be sent to stores.
- The duplicate requisition must also be signed by the healthcare staff member who accepted the new supply.

2. RECORDING:

Register:

- A complete record must be kept of every transaction involving methadone.

2a). Administration

- Recording of administration should be carried out by the pharmacist or the two nurses involved in administration.
- **As a daily record of the administration of Methadone is kept, it is acceptable to make a single daily entry in the register for the total amount of methadone dispensed each day.**
- The register and the daily issue forms constitute the complete record for the use of Methadone.

2b). Receipt:

- A record of each new supply of methadone received must be made in the controlled drugs register, stating date, supplier, and quantity received.
- The stock balance should be adjusted accordingly.
- This entry must be signed by the pharmacist/two nurses.

2c). Supply:

Daily Issue Sheets:

a. A daily record of the administration of Methadone must be kept, to comply with record keeping requirements. As outlined above, daily recording on both the daily sheets and a single daily entry in the register constitutes an acceptable record of methadone usage.

b. Methadone may only be dispensed and supplied on foot of a current valid prescription.

c. The pump must be calibrated each day before use, as recommended by the manufacturer.

d. The daily sheet must state each individual prisoner's name, DOB, PRIS, quantity administered to each patient. In addition it must state the total quantity issued on each day and must be signed by the pharmacist/two nurses.

e. A stock check should be carried out at the end of each daily administration i.e.
   - The total quantity administered as per daily sheet should be subtracted from the opening balance. This is the calculated balance.
   - The actual balance is then measured – this is the actual quantity left in stock.
   - The calculated balance and the actual balance should be identical, however due to the viscosity of the liquid, there may be a slight positive discrepancy.
   - Any positive balance (i.e. actual balance greater than the calculated balance) should be recalculated into the total stock.
   - A negative balance (i.e. actual balance less than the calculated balance) is never acceptable. Should this occur, it should be reported on the day to Deirdre O'Reilly or Frances Nangle-Connor by phone, email or hard copy. This will then be fully investigated.

- The balance forward is the actual amount in stock at the end of the day and this is then carried forward as the opening balance for the next day.

Register:
f. An entry is then made in the CD register, stating the actual balance remaining at the end of each day.

3. ADMINISTRATION

c. Methadone may only be dispensed and administered on foot of a current, valid prescription.
d. Ideally methadone should be dispensed and administered by Pharmacists.
In the absence of Pharmacists, dispensing and administration of methadone should be conducted by two Nurses.
c. Before administering methadone to a patient, the Pharmacist/Nurse:
   1) check the patient's name, photograph, number and location
   2) check the medication against the prescription
d. All methadone administration must take place in front of the Pharmacist/Nurse.
e. To ensure that the patient has swallowed the dose of methadone:
   1) Each patient should take a drink of water after each dose of methadone
   2) The patient should be supervised, in so far as is possible, to ensure that the methadone has been swallowed
   3) The patient should be engaged in conversation following medication administration, to assist in confirming that the methadone has been swallowed.
   4) Any suspicion of retention of methadone should be reported to the doctor.
f. Any wastage of controlled drugs should be recorded and the entry witnessed.
g. A signed record should be appropriately entered on the patient's file on PMRS.
h. The checking, preparation, administration or destruction of controlled drugs should be witnessed.

4. STORAGE

Schedule 2 and 3 Controlled Drugs, including methadone should be stored in a locked safe.
No other items, except controlled drugs, should be stored in this safe.
The key of this safe should at all times be kept on the person of one accountable staff member (pharmacist/nurse) who is accountable for the controlled drugs and should be passed on to the staff member taking over on the next shift. It should be kept separate from all other keys and should never be left in the lock, in a drawer or any other area. No other person should have access to this key.

The stock should be checked and signed off at each change over of staff by two nurses.

5. EMPTY METHADONE CONTAINERS

All empty methadone containers will be collected by the supplier, for recycling as follows:

- All empty methadone containers should be rinsed out.
- They should then be replaced, *without the caps*, in the original box in which they were received.
- When the box is full, it will be collected from the surgery by the supplier.

6. DISPOSAL OF PATIENT'S METHADONE

As a safety measure and to assist in risk management, any methadone found on the person of a patient committed to prison will be removed from that person and will not be returned on release.

Any such quantities should then be disposed of as outlined in IPS "Policy on Disposal of Patient's Legally Dispensed Methadone" – **See Appendix 4.**

APPENDIX 4

DISPOSAL OF PATIENT'S LEGALLY DISPENSED METHADONE

(Policy 9: Use of Methadone - Ordering, Dispensing, Administration & Recording)

IPS Healthcare Standards A/23

This policy assumes that any green liquid whether labelled as Methadone or not, found on the person of a prisoner, is and will be treated as Methadone.

1. Should a quantity of legally dispensed Methadone be found on the person of a prisoner on committal to prison, this should be immediately taken from the prisoner.

2. It should then be taken to the surgery and handed to a member of the healthcare staff.

3. The approximate volume should be estimated by the healthcare staff member.

4. An entry should be made in a separate section of the Controlled Drug Register, stating:

- Date received in surgery.
- Name, DOB, PRIS of prisoner on whose person Methadone was found.
- Name of clinic/pharmacy where supply dispensed
- Date on which dispensed.
- Approximate volume.
- Signature of two members of healthcare staff.

5. This supply should then be stored in the controlled drugs safe, separate from surgery stock.

6. **Disposal** - <u>All Dublin prisons:</u>

- Pinewood Healthcare have agreed to accept, for disposal, all such Methadone stock from each of the Dublin prisons.
- At regular intervals, when there is a reasonable amount of such Methadone in stock, David Brannigan, Pinewood Healthcare should be contacted on 087 8118209
- He will then, by arrangement, call to the prison surgery to collect this Methadone.
- He will supply the necessary paperwork, which should be completed, and signed by both a healthcare staff member and himself.
- An entry should then be made in the register, stating:

1) Date supply collected by Pinewood.
2) Total quantity collected.
3) Signature of two staff members.

- A copy of the completed Pinewood paperwork should be retained in the surgery, in the Controlled Drug Register.

7. **Disposal** - <u>all other prisons:</u>
Please inform the Co-ordinator of Pharmacy Services at 01 4616121 or
087 9292539, whenever there is a supply for disposal and appropriate local arrangements will be made.

APPENDIX 5

PSYCHIATRIC ASSESSMENT OF SUBSTANCE MISUSE DISORDERS

(Policy 20: Psychiatric Assessment of Substance Misuse Disorders)

Aims:

- **Identify the main diagnosis:**
  - Identify the quantity, pattern, and frequency of drug use
  - Evidence of features of dependence vs. harmful use
  - Evidence of withdrawal symptoms
- **Assessment of co-morbid conditions: psychological, psychiatric and physical**
- **Identify the consequences and risk of use**
- **Assessment of motivation for treatment and "readiness to change"**
- **Establishment of a therapeutic rapport in order to enhance an individuals motivation**
- **Identify areas that require interventions, so that goals can be set and a care plan developed.**
- **Assessment is an ongoing process, where reviews are required to adjust an individual's treatment plan**

Assessment of the following:

1. Diagnosis
ICD 10 Definitions

F10 –F19:
Mental and behavioural disorders due to the use of alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine, stimulants, hallucinogens, tobacco, volatile solvents, multiple drug use and use of other psychoactive substances.

Clinical states:
•**Acute intoxication**: a transient disorder resulting in disturbances in level of consciousness, cognition, perception, affect, behaviour or other psychophysiological functions and responses.

•**Harmful use:** A pattern of psychoactive substance use that is causing damage to health: physical and mental health.

•**Dependence Syndrome:**
If 3 or more of the following have been present together at some time in the previous year.
- A strong desire or sense of compulsion to take the drug
- Difficulties in controlling substance-taking behaviour
- Evidence of a withdrawal state
- Evidence of a change in tolerance
- Progressive neglect of alternative pleasures or interests. Increased amount of time necessary to obtain or take the substance or to recover from its effects.
- Persisting with substance use despite clear harmful consequences.

Another characteristic feature includes "narrowing of the personal repertoire" i.e. drinking in the same pattern despite social constraints that determine appropriate drinking.

- **Withdrawal State**

- **Withdrawal state with delirium I.e. DTs.**

- **Psychotic Disorder:** A cluster of psychotic symptoms that occur during or immediately after psychoactive substance misuse: Includes vivid hallucinations, misidentifications, delusions + / or ideas of reference, psychomotor disturbances, abnormal affect. Usually resolves within 1 month and fully at 6 months

- **Amnesic Syndrome:**

  Impairment of recent memory and learning new material, - Disturbances of time sense and telescoping of repeated events into one.
  Absence of impairment of immediate recall, consciousness or generalised cognitive impairment.
  Confabulation may be present. History of chronic substance use. Korsakoff's Psychosis.

- **Residual and late onset psychotic disorder:**
  Psychoactive substance induced changes in cognition, affect, personality, or behaviour persist beyond the period during which a psychoactive induced effect might reasonably be assumed to be operating.

2. Withdrawal State
A group of symptoms of variable clustering and severity occurring on withdrawal of a substance after repeated or prolonged and or high dose use of the substance

Alcohol withdrawal Syndrome: 6-24 hours after their last drink
Sweating, anxiety, diarrhoea, insomnia, restlessness, tremors, tachycardia, nausea, vomiting, headaches, weakness, seizures,
Delirium tremens: Confusion and clouded consciousness, distortion of perception, sensation and arousal giving visual and auditory hallucinations. Death can occur

Opiate withdrawal Syndrome:
Onset 8-12 hrs, peak 48-72 hrs.
"Cold-turkey", Nausea, Vomiting, Diarrhoea, Muscle cramps, Insomnia, rhinorrhoea, dilated pupils, goose flesh, yawning, sweating, runny eyes, increased pulse rate. Disappears within 7-10 days
Protracted abstinence syndrome: fatigue, malaise, craving for opioids, poor tolerance of stress. May last months

Sedative / hypnotic withdrawal syndrome:
Tremors, nausea, vomiting, tachycardia, postural hypotension, agitation, headaches, insomnia, weakness, seizures, transient hallucinations: visual, auditory, tactile, illusions, paranoid ideation.

Stimulant Withdrawal Syndrome i.e. cocaine
"Crash", depressed mood, agitation, anxiety, insomnia, anorexia, suicidal ideation, craving: 9 hrs – 4 days.
Later symptoms include exhaustion, hypersomnolence, depression, hyperphagia, anxiety, inactivity, amotivation, fatigue and anhedonia, craving

3. Physical Health Problems

4. Psychological / Psychiatric problems
Increased risk of anxiety, depression, suicidal ideation and suicide.

5. Risk Taking Behaviour
Injecting: increased risk of HIV and Hepatitis C if share equipment, needles, spoon, filter, barrels.
Risk of overdose: polysubstance misuse, mixing opiates with benzodiazepines and alcohol, injecting alone.

6. Stages of Change:
Pre-contemplative stage: The person is not considering change. They wish to continue to enjoy using drugs.
Contemplative Stage: Person is aware of the costs and negative effects of using drugs but is ambivalent about change
Preparation Stage:
Individuals want to change and are looking for direction on how to do this
Action Stage: Individuals are engaged in attempts to reduce or to stop drug use
Maintenance Stage: Individuals are continuing to maintain stability or abstinence. Relapse prevention is a key goal.

7. Identify the quantity, pattern, and frequency of drug use.

Previous attempts to reduce or to stop.

What has worked in the past?
What are possible triggers or relapse?

History: Psychiatric and Medical History

Current Drug Use (Last 30 days)
Identify the quantity, pattern, and frequency of drug use.

Heroin:

Amount per day: 1 bag approximates to ¼ grm of heroin.
Frequency: daily, 2-6 times per week, weekly, monthly etc.
Duration of current use
Mode of use: IV, smoking, skin-popping
Age of first use

Assess for use of benzodiazepines, zimovane, cocaine, amphetamines, extra methadone, ecstasy, alcohol, hallucinogens, cannabis and any other drug:

Amount, frequency, duration, mode and age of first use.

Assess a typical daily pattern of use.

Assess for current withdrawal symptoms

Assess for risk for HIV and Hepatitis C.

Have they ever shared any part of their equipment: spoon, filter, needle, barrel.
Have they shared with their partner?
Have they ever been tested for HIV and Hepatitis B+C
Date of last test?
If injecting in the last month, have they shared in the last month
Do they require further testing due to continued sharing?

Assess for psychiatric illness/ psychological morbidity:

Nature of symptoms
Duration and mode of onset of symptoms
Progression of symptoms over time
Relationship of symptoms with drug use

Past Drug use and Progression of drug use:

Age of first drug used and duration of use.
Progression of drug use over time
Age of first injecting

Past treatments for drug use.

Number of past detoxification programmes and methadone maintenance programmes received, dates and site of programmes

Past Medical History:

Any physical complications from alcohol and drug use
Are they diagnosed with HIV/ Hepatitis?
Has a specialist assessed them?
Are they receiving treatment?
Have they been vaccinated for Hepatitis?

Past Psychiatric History:

Any previous treatments for a psychiatric illness. Diagnosis? Where? What was the treatment received?
Any episodes of deliberate self-harm and when was the last episode
Are they attending a psychiatric service currently and what is the medication they are receiving?

Family History:

Any family history of addiction or psychiatric illness

Personal History:
Early life, childhood,
Schooling: Age of starting and leaving school. ? Exams,? Difficulties in school? i.e. learning, discipline, truancy
Training and Occupations

Psychosexual History:
Current sexual practices, sexual orientation, current relationships

Marital History / Partners

? partner using drugs
Children: ? children in care

Forensic History:
Past convictions, past prison sentences
? impending charges / court cases

Social History:
Living arrangements and composition of household on release from Prison
? on social welfare
? Homeless, B+B, rented accommodation etc on release from prison.

Premorbid personality

Mental State Examination:

Appearance and Behaviour
Speech
Mood: Subjectively and objectively
    Evidence of suicidal ideation and intent
    Evidence of homicidal ideation or intent
Thoughts: preoccupations, abnormal thoughts, thought disorder
Perceptions:
    Abnormal perceptions: illusions, hallucinations

Cognitive function:
    Orientation, attention and concentration, memory: immediate, recent and long term
    Intelligence
Insight:
    Precontemplative (no motivation), contemplative (ambivalent), Motivated.

Formulation

Diagnosis

APPENDIX 6

CURRENT PROCESSES IN THE MEDICAL UNIT INVOLVING PRISONERS ON A METHADONE MAINTENANCE PROGRAMME

(Policy 20: Psychiatric Assessment of Substance Misuse Disorders)

Type of Patient: multiple health needs, on higher doses of methadone and other medications, mental health needs, motivated to stabilise drug use.

- The Consultant Psychiatrist in Addiction/ their Deputy is responsible for patients on a methadone maintenance programme in the Medical Unit, specifically patients on F1, F2, F4, and attends the Medical Unit, once a week for a clinical session.

- A full history of current and past drug use, risk behaviours and a full psychiatric assessment is completed. An Initial Treatment Plan is discussed. Options include:

  A Detoxification programme,
  A Stabilisation / Detoxification Programme,
  A Methadone Maintenance programme.

- The methadone maintenance programme is adjusted accordingly based on the history obtained.
- Antidepressants / antipsychotics and other medications are prescribed based on the prisoner's mental state examination.
- The conditions of their contract for treatment is explained and if not already signed, will be signed by the patient.
- The treatment programme is explained to the patient and involves:
  - Giving the patient time to stabilise their drug use and a number of "Dates to clear" are given i.e.
    -7 days for opiates, cocaine, amphetamines
    -4 weeks for benzodiazepines.
  - If urines remain positive for drugs over a persistent period of time and various treatment interventions have been explored i.e. increased methadone doses, referral for counselling, other medications etc, then other options outlined in their contract of treatment are explored i.e. a reduction of their dose, a low dose programme for 2 weeks, recommended transfer to the main prison.
- Referrals are made to the psychologist / probation and welfare / GP and other agencies where appropriate, i.e. Consultant Hepatologist / Consultant in Infectious Diseases.
- Referral to a counsellor will be made when available to patients
- Need for testing for HIV and Hepatitis is assessed
- Pre-test discussion for viral testing is provided
- Referral to phlebotomy services is made.
- Consent can be given to obtain results from the Virus Reference Laboratory. (Standard Letter in Medical Unit)
- A letter is forwarded to the community treating agency requesting confirmation of a treatment place for an ongoing methadone maintenance programme on release from prison. (Standard Letter in Medical Unit)
- Nurses / Doctor complete the Entry Form to the Central List with the patient's signature.
- 2x weekly urine samples are taken.
- Nurses fill in urine results in the charts of all patients.
- Cumulative urine results from Claymon Laboratories are filed in a folder.
- Patients are reviewed depending on urine results, mental health issues, at their request, at the request of other professionals, or prior to discharge (if possible).
- Feedback is given to Healthcare staff on decisions made after each clinic. These decisions are documented in a Healthcare diary.
- Discussions about treatment and aftercare needs are discussed with the Probation and Welfare services with the patient's consent.
- If the patient is for release, a discharge letter is completed by the Healthcare staff in the Medical Unit and forwarded to the treating agency.

APPENDIX 7

USE OF NICOTINE REPLACEMENT THERAPY

(Policy 17: Nicotine Replacement Therapy)

1. Call to Surgery for a talk on smoking cessation and NRT
2. Programme to be recorded on this sheet
3. NRT must be prescribed.
4. One box of patches to be given at a time
5. Empty box with used patches to be returned to surgery for disposal and replacement.
6. Please report any allergies or sensitivities to the patches
7. Smoking whilst using patches is not permitted
8. Patches are strictly **not to be shared** with anyone else
9. One attempt at NRT within a 6 month period

Details

Name: ________________________ D.O.B.: ______________
How many cigarettes smoked per day?: ___________
How many years smoking? ___________
Date ceased or to cease smoking?: ___________
Brief Intervention YES/NO
Has patient taken NRT before?: YES/NO
If so, which one?: ___________
When was last time NRT was taken?: ___________
Has there ever been a reaction to NRT? ___________

Programme

(If you smoke >10 cigarettes a day follow 3 steps below. If you smoke <10 daily take step 2 for 6 weeks followed by step 3 for 2 weeks)

STEP 1	STEP2	STEP3
Week 1 _________	Week 1 _________	Week 1 _________
Week 2 _________	Week 2 _________	Week 2 _________
Week 3 _________	Week 3 _________	Week 3 _________
Week 4 _________	Week 4 _________	Week 4 _________
Week 5 _________	Week 5 _________	Week 5 _________
Week 6 _________	Week 6 _________	Week 6 _________

I have been informed of the above programme and conditions and agree to its conditions in ________________ (Name of Institution).

Signed: ________________ Witnessed: ________________
Date: ________________

APPENDIX 8

CHILDREN FIRST

(Policy 24: Child Protection)

Children First
National Guidelines
for the Protection and
Welfare of Children
A Summary
September 1999

Chapter One
Introduction 5
Objectives 5
Duty to Protect Children and Support Families 6
Principles for Best Practice in Child Protection 6
Chapter Two
Definition and Recognition of Child Abuse 9
Neglect 9
Emotional Abuse 10
Physical Abuse 11
Sexual Abuse 11
Recognising Child Abuse 12
Chapter Three
Reporting Child Protection Concerns 15
Responsibility to Report 16
Standard Reporting Procedure 16
Co-operation with Parents/carers 18
Chapter Four
Joint Working and Co-operation Roles and Responsibilities of
Agencies and Personnel Working with Children 19
Individual and Corporate Responsibilities in Reporting Child
Abuse 20
Schools/Clubs/Organisations 21
Health Professionals 21
Welfare Services 22
Chapter Five
Child Protection Practices Operated by the Health Boards and
An Garda Sı ´ocha´na 23
Emergency Action to Protect a Child 23
Assessment and Investigation 24
Notification to the Child Care Manager/designate 24
Child Protection Meetings 24
Inter-agency and Inter-professional Co-operation 25
3
Chapter Six
Specially Vulnerable Children and Abuse Outside the Home 27
Children with Disabilities 27
Children Out of Home 27
Organised Abuse 28
Peer Abuse 29
Bullying 29
Chapter Seven
Support Services to Children and Families 31
Dimensions of Family Support 31
Chapter Eight
Allegations of Abuse Against Employees and Volunteers 33
General Procedures 33
Guidance on Reporting 34
Employer's Responsibility to Report to Statutory Authorities 34
Procedures for Dealing with Employees and Employer's Duty
of Care to Children 35
Guidance for Health Boards 37
Chapter Nine

Local Arrangements: Procedures and Training 39
Local Procedures and Guidelines 39
Training 39
Recommended Reading 41
Appendix 1
List of Health Board Addresses 43
Appendix 2
Suggested Template for a Standard Reporting Form 49
4

Chapter One

Introduction

New guidelines, entitled 'Children First: National Guidelines for the Protection And Welfare of Children' were introduced in 1999. These guidelines are intended to assist people in identifying and reporting child abuse and to improve professional practice in both statutory and voluntary agencies and organisations that provide services for children and families.

This booklet offers a summarised version of 'Children First'. It is expected that these National Guidelines will be complemented by local guidelines specific to the needs of regional health boards, as well as individual disciplines and organisations. Any such guidance must adopt the basic aims and objectives outlined in this document.

These guidelines aim to offer a comprehensive framework to assist professionals and other persons who have contact with children and wish to deal with any concerns they may have in relation to their safety and wellbeing. The guidelines embody the principles contained in the UN Convention on the Rights of the Child which was ratified by Ireland in 1992. (It should be noted that the Child Care Act, 1991, provides the legislative basis for dealing with children in need of care and protection)1.

Objectives

The objectives of the National Guidelines are to improve the identification, reporting, assessment, treatment and management of child abuse, clarify the responsibilities of various professionals and

1 For a comprehensive discussion of other key legislative provisions, see the full version of 'Children First: Guidelines for the Protection and Welfare of Children'.

5

individuals within organisations and enhance communication and coordination of information between disciplines and organisations.

Protecting and supporting children frequently involves the collaboration of a variety of personnel

Duty to Protect Children and Support Families

Parents/carers have primary responsibility for the care and protection of their children. When parents/carers do not or cannot fulfil this responsibility, it may be necessary for health boards to intervene. The wider community also has a responsibility for the welfare and protection of children. All personnel involved in organisations working with children should be alert to the possibility of child abuse. They need to be aware of their obligations to convey any reasonable concerns or suspicions to the health board and to be informed of the correct procedures for doing so.

Principles for Best Practice in Child Protection

The principles that should inform best practice in child protection include the following:

(i) the welfare of children is of paramount importance
(ii) a proper balance must be struck between protecting children and respecting the rights and needs of parents/carers and families; but where there is conflict, the child's welfare must come first.
(iii) children have a right to be heard and taken seriously. Taking account of their age and level of understanding, they should be consulted and involved in relation to all matters and decisions that affect their lives.

6

(iv) early intervention and support should be available to

promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection.
(v) parents/carers have a right to respect and should be consulted and involved in matters which concern their family.
(vi) actions taken to protect a child, including assessment, should not in themselves be abusive or cause the child unnecessary distress. Every action and procedure should consider the overall needs of the child.
(vii) intervention should not deal with the child in isolation; the child must be seen in a family setting.
(viii) the criminal dimension of any action cannot be ignored.
(ix) children should only be separated from parents/carers when all alternative means of protecting them have been exhausted. Re-union should always be considered.
(x) effective prevention, detection and treatment of child abuse require a co-ordinated multi-disciplinary approach.
(xi) in practice, effective child protection requires compulsory training and clarity of responsibility for personnel involved in organisations working with children.
(xii) early intervention and support should be available to promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection.
7

Chapter Two
Definition and Recognition of Child Abuse

Introduction

Child abuse can be categorised into four different types: neglect, emotional abuse, physical abuse and sexual abuse. A child2 may be subjected to more than one form of abuse at any given time. The National Guidelines have adopted the following definitions of child abuse:

Neglect

Neglect is normally defined in terms of an *omission,* where a child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, or medical care.

Harm can be defined as the ill treatment or the impairment of the health or development of a child. Whether it is *significant* is determined by his/her health and development as compared to that which could reasonably be expected of a similar child.

Neglect generally becomes apparent in different ways *over a period of time* rather than at one specific point. For instance, a child who suffers a series of minor injuries is not having his or her needs met for supervision and safety. A child whose ongoing failure to gain weight

2 For the purposes of these guidelines, a ‘child’ means an unmarried person under the age of 18 years.

9

or whose height is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived or intellectual stimulation. The *threshold of significant harm* is reached when the child’s needs are neglected to the extent

that his or her well being and/or development are severely affected.

Emotional Abuse

Emotional abuse is normally to be found in the *relationship* between a caregiver and a child rather than in a specific event or pattern of events. It occurs when a child's needs for affection, approval, consistency and security are not met. It is rarely manifested in terms of physical symptoms. Examples of emotional abuse include:

(i) persistent criticism, sarcasm, hostility or blaming;
(ii) conditional parenting, in which the level of care shown to a child is made contingent on his or her behaviours or actions;
(iii) emotional unavailability by the child's parent/carer;
(iv) unresponsiveness, inconsistent or inappropriate expectations of a child;
(v) premature imposition of responsibility on a child;
(vi) unrealistic or inappropriate expectations of a child's capacity to understand something or to behave and control himself in a certain way;
(vii) under or over or under protection of a child;
(viii) failure to show interest in, or provide age appropriate opportunities for, a child's cognitive and emotional development;
(ix) use of unreasonable or over harsh disciplinary measures;
(x) exposure to domestic violence.

10

Children show signs of emotional abuse by their behaviour (for example, excessive clinginess to or avoidance of the parent/carer), their emotional state (low self-esteem, unhappiness), or their development (non-organic failure to thrive). The *threshold of significant harm* is reached when abusive interactions become *typical* of the relationship between the child and parent/carer.

Physical Abuse

Physical abuse is any form of non-accidental injury that causes significant harm to a child, including:

(i) shaking;
(ii) use of excessive force in handling;
(iii) deliberate poisoning;
(iv) suffocation;
(v) Munchausen's syndrome by proxy (where parents fabricate stories of illness about their child or cause physical signs of illness);
(vi) allowing or creating a substantial risk of significant harm to a child.

Sexual Abuse[3]

Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others. For example:

(i) exposure of the sexual organs or any sexual act intentionally performed in the presence of a child;

3 The definition of child sexual abuse presented here is not a legal definition, and is not intended to be a description of the criminal offence of sexual assault.

11

(ii) intentional touching or molesting of the body of a child whether by a person or object for the purpose of sexual arousal or gratification;
(iii) masturbation in the presence of a child or involvement of the child in the act of masturbation;
(iv) sexual intercourse with the child, whether oral, vaginal or anal;
(v) sexual exploitation of a child;
(vi) consensual sexual activity between an adult and a child under 17 years. In relation to child sexual abuse, it should be noted that, for the purposes of the criminal law, the age

of consent to sexual intercourse is 17 years. This means, for example, that sexual intercourse between a 16 year old girl and her 17 year old boyfriend is illegal, although it might not be regarded as constituting child sexual abuse.

Recognising Child Abuse

The ability to recognise child abuse depends as much on a person's willingness to accept the possibility of its existence as it does on knowledge and information. It is important to note that child abuse is not always readily visible, and may not be as clearly observable as the 'text book' scenarios outlined in these guidelines suggest. The recognition of abuse normally runs along three stages,

(i) considering the possibility — if a child appears to have suffered an inexplicable and suspicious looking injury, seems distressed without obvious reason, displays unusual behavioural problems or appears fearful in the company of parents/carers.

12

(ii) observing signs of abuse — a cluster or pattern of signs is the most reliable indicator of abuse. Children may make direct or indirect disclosures, which should always be taken seriously. Less obvious disclosures may be gently explored with a child, without direct questioning (which may be more usefully carried out by the health board or An Garda Sı ´ocha´na). Play situations such as drawing or story telling may reveal significant information. Indications of harm must always be considered in relation to the child's social and family context, and it is important to always be open to alternative explanations.

(iii) recording of information — it is important to establish the grounds for concern by obtaining as much detailed information as possible. Observations should be recorded and should include dates, times, names, locations, context and any other information which could be considered relevant or which might facilitate further assessment/ investigation.

13

Chapter Three
Reporting Child Protection Concerns

Introduction

Child abuse is a difficult subject, and it is understandable that people may at times be reluctant to acknowledge its existence. Members of the public or professionals may be afraid of being thought insensitive, afraid of breaking confidence or afraid of being disloyal if they report suspected child abuse to the health board or An Garda Sı ´ocha´na. However, early intervention may reduce the risk of serious harm occurring to a child in the future. Persons uncertain about the validity of their concerns may discuss them with a health board social worker or public health nurse. This may enable them to decide whether or not to make a formal report.

The *Protection for Persons Reporting Child Abuse Act, 1998* provides immunity from civil liability to persons who report child abuse 'reasonably and in good faith' to designated officers* of health boards

* In accordance with the power granted to him under Section 2, subsection (2) of the Act, the Minister has directed (January 1999) that the Chief Executive Officer of each health board should appoint as designated officers each person falling within the following categories of officer of the health board:

Social Workers
Child Care Workers
Public Health Nurses
Hospital Consultants
Psychiatrists
Non-Consultant Hospital Doctors
All other health board medical and dental personnel

Community Welfare Officers
Speech and Language Therapists
All health board nursing personnel
Psychologists
Radiographers
Physiotherapists
Occupational Therapists
Health Education Officers
Substance Abuse Counsellors
Care Assistants.
15
or any member of An Garda Sı ´ocha´na. This means that, even if a reported suspicion of child abuse proves unfounded, a plaintiff who took an action would have to prove that the reporter had not acted reasonably and in good faith in making the report.
Giving information to others for the protection of a child does not constitute a breach of confidentiality.

Responsibility to Report

Any person, who suspects that a child is being abused, or is at risk of abuse, has a responsibility to report their concerns to the health board. This responsibility is particularly relevant to professionals such as teachers, child care workers and health professionals who have regular contact with children in the course of their work. It is also an important responsibility for staff and volunteers involved in sports clubs, parish activities, youth clubs and other organisations catering for children.
The following examples would constitute reasonable grounds for concern:
(i) a specific indication from a child that (s)he was abused;
(ii) a statement from a person who witnessed abuse;
(iii) an illness, injury or behaviour consistent with abuse;
(iv) a symptom which may not in itself be totally consistent with abuse, but which is support by corroborative evidence of deliberate harm or negligence;
(v) consistent signs of neglect over a period of time.
A suspicion, which is not supported by any objective signs of abuse, would not constitute a reasonable suspicion, or reasonable grounds for concern

Standard Reporting Procedure

If child abuse is suspected or alleged, the following steps should be taken by professionals and members of the public who come into contact with children
16
(i) a report should be made to the health board in person, by phone or in writing. Each health board has a duty social worker who is available each day to meet with or talk on the telephone to persons wishing to report child protection concerns. (A list of contact numbers is available in Appendix 1)
(ii) it is generally most helpful if personal contact is made with the duty social worker by the person who first witnessed or suspected the alleged child abuse.
(iii) **in the event of an emergency or the non-availability of health board staff, a report may be made to An Garda Sı´ocha´na at any Garda Station.**
NOTE: A suggested template for the Standard Reporting Procedure is contained in Appendix 2, which may be of use for staff or volunteers in organisations who work with children or are in contact with children.
The health board or An Garda Sı´ocha´na, on receiving a report, will require as much as possible of the following information:
(i) names and addresses of the child, parents/carers and any other children in the family;
(ii) name and address of the person alleged to be causing

harm to the child;
(iii) a full account of the current concern about the child's
safety or welfare;
(iv) the source of any information which is being discussed with
the health board;
(v) dates of any incidents being reported;
(vi) circumstances in which the incident or concern arose;
(vii) any explanation offered to account for the risk, injury or
concern;
(viii) the child's own statement if relevant;
17
(ix) any other information about the family, particularly any
difficulties which they may be experiencing;
(x) any factors relating to the family which could be
considered supportive or protective, e.g. helpful family
members, neighbours or services;
(xi) name of child's school;
(xii) name of child's general practitioner;
(xiii) reporter's own involvement with child and parents/carers;
(xiv) details of any action already taken in relation to the child's
safety and welfare;
(xv) names and addresses of any agency or key person involved
with the family;
(xvi) identity of person reporting, including name, address,
telephone number, occupation and relationship with the
family.

In cases of emergency, where a child appears to be at immediate and
serious risk, and a duty social worker is unavailable, An Garda Sı ´ocha´na
should be contacted. **Under no circumstances should a child be left
in a dangerous situation pending health board intervention.**

Co-operation with Parents/carers

Any **professional** who suspects child abuse should inform the family if
a report is likely to be submitted to the health board or An Garda
Sı ´ocha´na, unless doing so is likely to endanger the child. Co-operation
with the family is essential in order to ensure the safety of the child; it
is more likely to be achieved if professionals can develop an open and
honest relationship with parents/carers.

Involvement in a child protection assessment can be difficult for
parents/carers. Families may have rights to know what is said about
them and to contribute to important decisions about their lives and
those of their children. Sensitivity must be used, and parents/ carers
should be made fully aware of what is expected of them. Professional
staff must strike a balance between showing respect for families and
using authority appropriately.
18

Chapter Four
Joint Working and Co-operation
Roles and Responsibilities of Agencies and Personnel Working with Children

Introduction

The health board has overall responsibility for the assessment and
management of child protection concerns. At the same time, An Garda
Sı ´ocha´na has responsibility for the investigation of alleged offences.
Other organisations have major contributions to make to the safety
and welfare of children. No one professional or agency has all the skills,
knowledge or resources necessary to comprehensively meet all the
requirements of an individual case. It is essential therefore that a coordinated
response is made by **all** professionals involved with a child
and his or her carer/s.

Effective inter-agency co-operation will depend on
(i) understanding and acceptance by all professionals and
persons working with children of their responsibilities and
roles in the promotion of child welfare
(ii) mutual trust and sharing of information

(iii) willingness of personnel to respect the contributions made
by each other, irrespective of status and position within
agencies and organisations.
19
Inter-agency co-operation is as important in the later stages of child
protection work as it is at the outset. Efforts should be consistently
made by all personnel involved in a case to remain in contact, and to
communicate any relevant information to the key worker, who is
usually the health board social worker.

**Individual and Corporate Responsibilities in Reporting
Child Abuse**

All organisations, whether statutory or voluntary, have an overall
corporate responsibility to safeguard children, and should pay
particular attention to
(i) safe and clearly defined methods of selecting staff and
volunteers
(ii) developing effective procedures for the reporting and
management of child protection concerns
(iii) identifying a designated staff member/volunteer to act as a
liaison with outside agencies and a resource person to any
staff member or volunteer who has child protection
concerns. The designated person will be responsible for
reporting allegations or suspicions of child abuse to the
health boards or An Garda Sı ´ocha´na
The *Protection for Persons Reporting Child Abuse Act, 1998* makes
provision for the protection from civil liability of persons who have
reported child abuse 'reasonably and in good faith'. This protection
applies to organisations as well as individuals. It is considered therefore
that, in the first instance, it is organisations that employ staff or use
volunteers that should assume responsibility for reporting child abuse
to the appropriate authorities. Reports to the health boards or An
Garda Sı ´ocha´na should be made following the Standard Reporting
Procedure (See Chapter Three).
20
In those cases where the organisation decides not to refer concerns to
the health board or An Garda Sı ´ocha´na, the individual staff or volunteer
who raised the concern should be given a clear written statement of
the reasons why the organisation is not taking action. The staff or
volunteer should be advised that if they remain concerned about the
situation, they are free to consult with, or report to, the health board
or An Garda Sı ´ocha´na.

Schools/ Clubs / Organisations

If a child alleges that he or she is being harmed or is at risk of harm
from a parent/carer or any other person, the person who receives the
information should listen carefully and supportively. This also applies if
a parent/carer or any other person discloses that he or she has harmed
or is at risk of harming a child.
The child should not be interviewed formally or in detail, as this may
be best done by the health board or An Garda Sı ´ocha´na. The staff
member/ volunteer needs to gather enough information to establish
grounds for concern, record the conversation accurately and then
inform the person in the school, club or organisation who is
responsible for reporting the matter to the health board or An Garda
Sı ´ocha´na.

Health Professionals

Health professionals in statutory, voluntary and private services are well
placed to identify child protection concerns and to participate in initial
assessment and even longer-term management. These professionals
include general practitioners, medical consultants, dentists, those
working in hospitals, disability services, therapeutic services, adult
mental health services and child and adolescent psychiatric services
Any health professional who is satisfied that there are reasonable
grounds for suspecting that a child is being harmed or is at risk of harm
21

should immediately inform the health board in line with the Standard Reporting Procedure.

Health professionals who are involved in the initial or longer-term treatment of children who are considered to be at risk should attend child protection conferences and child protection reviews when invited. In addition, they must record and communicate any ongoing concerns to the key worker involved, who will normally be the health board social worker.

Welfare Services

Community welfare officers, housing welfare officers, probation and welfare officers, school attendance officers and others working in a welfare capacity may encounter situations which give rise to suspicions of child abuse in the course of their daily work. Reports should be made to the health board using the Standard Reporting Procedure. Any child protection concerns which later arise in relation to these children and families should also be communicated to the health board.

Confidentiality must never be promised to a person making a disclosure. The requirement to report to the health board must be explained in a supportive manner to the child. The parents/carers should also be informed of the intention to report unless it is considered that doing so would put the child at risk.

22

Chapter Five
Child Protection Practices
Operated by the Health Boards
and An Garda Sı´ocha´na

Introduction

A joint protocol has been agreed between the health boards and An Garda Sı ´ocha´na, whereby each organisation will notify the other of all reports of suspected child abuse which are made to them, and both are obliged to conduct a preliminary assessment/investigation in consultation with each other. Reports which are made anonymously will be followed up, but reporters will be informed that anonymity may greatly restrict the ability of professionals to intervene to protect a child.

It is important to note that the ability of the health board and An Garda Sı´ocha´na to respond to reports of suspected child abuse will depend on the quality and extent of information that is reported to them.

Emergency Action to Protect a Child

If it appears, on receipt of a report of suspected child abuse, that a child has been harmed or is at immediate risk of harm, emergency action will be taken by the health board or An Garda Sı ´ocha´na. This may involve having the child medially examined, and/or moving the child to a safe environment such as a foster home, or to the home of relatives. This intervention may be made voluntarily with the parents/carers' consent, or may involve an Emergency Care Order under the Child Care Act 1991.

23

Assessment and Investigation

Where the perceived harm or risk to the child does not appear to warrant emergency action, the assessment/ investigation will be carried out as quickly as possible in a co-ordinated manner, in consultation with any other professionals who are involved with the child and parents/carers. This will involve interviews with the child and parents/carers, and possible referral to medical or specialist services for more detailed assessment. An Garda Sı ´ocha´na will prepare a file for the Director of Public Prosecutions if appropriate.

Notification to the Child Care Manager/designate

The Child Protection Notification System is a health board record of every child about whom, following a preliminary assessment, there is

a child protection concern. Notifications are first made to the Child Care Manager by the health board staff member who carries out the initial assessment of a child protection concern. The Child Care Manager will ensure that all notified reports are reviewed initially and at six monthly intervals until a final outcome of assessment is known and an agreed intervention has been put in place.

Child Protection Meetings.

Three types of child protection meeting may be organised by the health board during the management of a case

(i) A **strategy meeting**, which may be held at the outset of a child protection assessment, when it appears that a child is at serious risk and in need of immediate protection or at any point in an assessment when it is deemed appropriate. This meeting will normally involve health board staff and members of An Garda Sı ´ocha´na, but may involve any or all other professionals involved. Its main aims are to share information and plan a strategy for early intervention and further assessment.

(ii) A **child protection conference**, which may take place when initial enquiries and any necessary emergency actions have taken place. Its participants include all professionals involved in the case. The child (where appropriate) and the child's parents/carers should be invited unless a specific reason for their exclusion is identified. Its aims are to pool all available information, outline a child protection plan, and identify the tasks to be carried out by different professionals. All professionals who are invited to child protection conferences should attend, and produce written reports in advance for the Chairperson, who will normally be the Child Care Manager/designate. The child protection conference will usually be followed by completion of a comprehensive assessment, and finalisation of the child protection plan.

(iii) **Child protection reviews**, which are held at six monthly intervals where a child's name is in the Child Protection Notification System, where (s)he is still residing with his or her parents/carers and where (s)he is still considered to be at risk. Child protection reviews should be attended by the core group of professionals involved with the case, and each should submit a written report in advance. The child (where appropriate) and the child's parents/carers should be invited unless a specific reason for their exclusion is identified. The aims of a child protection review are to consider the child's current situation, co-ordinate the views of participants, and amend the child protection plan.

Inter-agency and Inter-professional Co-operation

Co-operation between disciplines and agencies is essential throughout the lifetime of a child protection case. Commitment and flexibility in relation to carrying out the work specified in the child protection plan, together with willingness to exchange information promptly will be required from all professionals who are involved with the child.

Chapter Six
Specially Vulnerable Children and Abuse Outside the Home

Introduction

Children in certain situations are especially vulnerable to abuse. These include children with disabilities and children who, for one reason or another are separated from parents or other family members and depend on others for their care and protection. The same categories of abuse — neglect, emotional abuse, physical abuse and sexual abuse — may be applicable, but may take a slightly different form, for example harsh disciplinary or behavioural regimes or inappropriate use of medication or physical restraints.

Children with Disabilities

Children with disabilities can be more at risk of abuse because they may experience

- sensory and communication difficulties
- dependence on others for assistance including intimate care
- limited understanding of sexuality or sexual behaviour
- contact with numerous carers and helpers
- fear of not being believed
- perceived unreliability as witnesses.

Children Out of Home

Children who are without accommodation and children who have been placed by the health board in foster or residential care may be at special risk for the following reasons:

(i) they may have previously been abused

27

(ii) they may be at risk from peers who have suffered abuse

(iii) they may be dependent on a range of different persons for their care and feel powerless to take action if abused.

Procedures exist for the protection of children in out of home care and these should be followed by all staff and carers. However, it is also important that children in care are fully aware of complaints systems, and have opportunities to make their problems known to others who are in a position to help them. Action to be taken in response to allegations of abuse against members of staff are outlined in Chapter Eight.

Organised Abuse

Organised abuse occurs rarely but presents particularly complex problems. Essentially, organised abuse occurs when either one person moves into an area or institution and systematically entraps children for abusive purposes (mainly sexually) or when two or more adults conspire to similarly abuse children, using inducements. It can occur in different settings, such as the family, extended family, community or institution. It is particularly associated with the following factors:

(i) there may be numerous victims. Sometimes, help-lines and newspapers advertisements are necessary in order to contact victims;

(ii) victims may be under particular pressure not to disclose because of feelings of shame and responsibility;

(iii) some victims may have colluded with abusers to entrap other children and may have gone on to become abusers themselves.

Any person who suspects the existence of organised abuse must contact the health board or An Garda Sı ´ocha´na without delay. The

28

investigation of organised abuse may require prolonged surveillance by An Garda Sı ´ocha´na, and information must be treated with particular sensitivity.

Peer Abuse

In some cases of child abuse, the alleged perpetrator will be a child. In these situations, the child protection procedures should be adhered to for both the victim and alleged abuser, that is, it should be considered a child protection issue for both children.

Work must be done to ensure that perpetrators of abuse, even when they are children themselves, take responsibility for their behaviour and acknowledge that the behaviour is unacceptable.

It is important that clarity exists in respect of which behaviours constitute peer abuse, particularly child sexual abuse. Consultation with the health board should help to clarify the nature of any sexual behaviour by children which gives rise to concern.

Bullying

Bullying can be defined as repeated verbal, psychological or physical aggression conducted by an individual or group against others. It is behaviour which is intentionally aggravating and intimidating, and occurs mainly in social environments such as schools, clubs and other organisations working with children. It includes behaviours such as teasing, taunting, threatening, hitting or extortion behaviour by one or

more children against a victim. While the more extreme forms of bullying would be regarded as physical or emotional abuse and are reportable to health board or An Garda Sı ´ocha´na, dealing with bullying behaviour is normally the responsibility of the school or organisation where it is taking place. Training for teachers and staff/volunteers in organisations working with children should include modules on raising awareness and developing techniques for dealing with bullying.
29

Chapter Seven
Support Services to Children and Families

Introduction

Many of the children who come to the attention of the various services are living in difficult and stressful environments. Their families may be experiencing a variety of personal, social and health problems, and while children are not necessarily being abused in these situations, they may be at risk of future harm.

Interventions to support families who are experiencing difficulties can greatly reduce the possibility of future risk or harm. Support may be given to families through the direct services of statutory and voluntary organisations, but also informally through extended families, friends, neighbourhoods, communities, parishes and other local networks.

Dimensions of Family Support

Family support may be offered at different levels

(i) services specifically directed at children, aimed at increasing self confidence, self-esteem, social skills, enabling children to get over traumatic or damaging experiences or simply providing children with a break from a stressful environment. These services can range from clinical treatment, respite care (formal or informal) to provision of after school projects and involvement with local sport and recreation clubs and voluntary associations.
31

(ii) services to support families which are aimed at enhancing the skills of parents/carers by providing direct practical help, support and/or counselling. These can include respite care, direct financial help, and advice about housing, financial and welfare matters.

Early intervention can prevent worsening of current difficulties for children and families. It can reduce future risk, help families to develop strategies for coping with stress, and prevent children from being separated from their parents/carers.
32

Chapter Eight
Allegations of Abuse Against Employees and Volunteers

Introduction

Allegations of abuse may be made against employees (who for the purposes of these guidelines include paid staff, foster parents and unpaid volunteers). Employers may encompass disability organisations, schools, creches, or non-governmental organisations such as sports clubs. These guidelines are offered to assist managers in having due regard for the rights and interests of the child on the one hand, and those of the employee against whom the allegation is made on the other hand.

General Procedures

It is important to note that there are two procedures to be followed here:

(i) the reporting procedure in respect of the child

(ii) the procedure for dealing with the employee.

In general it is recommended that the same person should not have responsibility for dealing with both the reporting issues and the employment issues. It is preferable to separate these issues and manage them independently. These procedures should be followed in the event of suspicion or disclosure of abuse against an employee.

Staff/volunteers may be subjected to erroneous or malicious allegations. Therefore any allegation of abuse should be dealt with sensitively and support provided for staff including counselling where
33
necessary. However, the primary goal is to protect the child while taking care to treat the employee fairly.

Guidance on Reporting

All organisations providing services to children must have clear written procedures on action to be taken when allegations of abuse against employees are received. Guidance should be provided for both children and employees on how to report suspected child abuse. The need for awareness and the requirement to report concerns should be reinforced through training and supervision.

Employers should ensure that children and staff/volunteers are aware of internal line management reporting procedures. They should also be aware of the appropriate authorities to which they should report *outside* the organisation (i.e. the health board or An Garda Sı ´ocha´na) if they are inhibited for any reason from reporting the incident internally or where they are dissatisfied with the internal response.

Employer's Responsibility to Report to Statutory Authorities

Where an employer becomes aware of an allegation of abuse by an employee the standard procedure for reporting allegations to the health board should be followed without delay (see Chapter Three). Health boards should have their own internal reporting procedures in place in regard to allegations made against their employees.

Action taken in reporting an allegation of child abuse against an employee should be based on an opinion formed reasonably and in good faith. When an allegation is received it should be assessed promptly and carefully. It will be necessary to decide whether a formal report should be made to the health board; this decision should be based on reasonable grounds for concern as outlined in Chapter Two.
34
When an employer becomes aware of an allegation of abuse of a child or children by an employee during the execution of that employee's duties, the employer should inform the employee of the following:

(i) the fact that an allegation has been made against him/her;
(ii) the nature of the allegation.

The employee should be afforded an opportunity to respond. The employer should note the response and pass on this information when making the formal report to the health board.

Organisations as well as individuals may avail of the immunity from civil liability provided in the Protections for Persons Reporting Child Abuse Act, 1998 provided they report 'reasonably and in good faith' to the appropriate authorities. Section 3(1) of the Act states:

'3(1) A person who, apart from this section, would be so liable shall not be liable in damages in respect of the communication, whether in writing or otherwise, by him or her to an appropriate person of his or her opinion that
(*a*) a child has been or is being assaulted, ill-treated, neglected or sexually abused, or
(*b*) a child's health, development or welfare has been or is being avoidably impaired or neglected,
unless it is proved that he or she has not acted reasonably and in good faith in forming that opinion and communicating it to the appropriate person.'

Procedures for Dealing with Employees and Employer's Duty of Care to Children

Employers have a dual responsibility in respect of both the child and the employee. All employers should have **agreed** procedures to
35
address situations where allegations of child abuse are made against an **employee.** When an allegation is made against an employee, the following steps should be taken:

(i) Action should be guided by the agreed procedures, the applicable employment contract and the rules of natural

justice.
(ii) The Chairperson (or equivalent head of organisation) should be informed as soon as possible.
(iii) The first priority should be to ensure that no child is exposed to unnecessary risk. The employer should as a matter of urgency take any necessary protective measures. These measures should be proportionate to the level of risk and should not unreasonably penalise the employee, financially or otherwise, unless necessary to protect children. Where protective measures do penalise the employee, it is important that early consideration be given to the case.
(iv) The follow up on an allegation of abuse against an employee should be made in consultation with the health board and An Garda Sı ´ocha´na. An immediate meeting should be arranged with these two agencies for this purpose.
(v) After these consultation referred to above and when pursuing the question of the future position of the employee, the Chairperson (or equivalent head of organisation) should advise the person accused of the allegation and the agreed procedures should be followed.
(vi) Employers should take care to ensure that actions taken by them do not undermine or frustrate any investigations being conducted by the health board or An Garda Sı ´ocha´na. It is strongly recommended that employers maintain a close liaison with these authorities to achieve this.
36

Guidance for Health Boards

Health boards will regularly receive allegations of abuse against people who have contact with children in their workplace or in a sports or youth club. If the health board considers that children are, or may be, at risk from the alleged abuser, they should contact the institution or employer immediately. In this situation it is not necessary to notify the alleged abuser in advance of the allegations against him or her.
Where a health board proposes to notify an employer or person-incharge of a club about an alleged abuser in their workplace, and where there is no immediate danger to children, the alleged abuser must be notified in advance of the allegations against him/her. The approach to an employer/person-in-charge in such cases may take place at any stage in the wider investigation and it may be practical that such an approach does not take place until any criminal or health board investigation has concluded.
Health boards should put arrangements in place to provide feedback to employers/persons-in-charge in regard to the progress of a child abuse investigation involving an employee. Efforts should be made by health boards to investigate complaints against employees/volunteers promptly and to complete their assessment as quickly as possible bearing in mined the serious implications for the innocent employee/volunteer. Employers/persons-in-charge should be notified of the outcome of an investigation. The health board should pass on reports and records to the employer and to the employee/volunteer in question where appropriate. This will assist the employer/person-incharge in reaching a decision as to the action to be taken in the longer term concerning the employee/volunteer.

37

Chapter Nine
Local Arrangements: Procedures and Training

Local Procedures and Guidelines

Statutory and voluntary/community organisations providing services for children should produce their own procedures, in line with these National Guidelines. The procedures should be appropriate to local circumstances. They should provide

(i) clear descriptions of responsibility at local level, both individual and corporate

(ii) procedures for reporting child protection concerns and arrangements for inter-agency co-operation
(iii) an outline of the key elements of assessment and investigation as operated by the health board and An Garda Sı ´ocha´na
(iv) an outline of arrangements for training and support of staff
(v) guidance on the involvement of families and children in child protection and welfare work

Training

Training in child protection and welfare must be provided in all organisations that offer services to children. The key elements of effective training are:
(i) the inclusion of different disciplines and agencies
39
(ii) a focus on child protection and welfare legislation and policy along with national and local procedures
(iii) dissemination of knowledge about child abuse, including physical and behavioural signs, effects and appropriate interventions
(iv) A focus on inter-professional and inter-agency work along with the roles and responsibilities of individuals and organisations.
(v) Dissemination of information about local services, contact addresses and methods of referral.
As well as providing in-service training, organisations should encourage and facilitate employees/volunteers to participate in external training such as conferences, seminars and post-qualifying courses.
40

Recommended Reading

Buckley, H., Skehill, C. and O'Sullivan, E., (1997) *Child Protection Practices in Ireland: A Case Study.* Dublin: Oak Tree Press.
Dartington Social Research Unit (1995) *Child Protection: Messages from Research.* London: HMSO.
Department of Health (1994) *Shaping a healthier future: a strategy for effective healthcare in the 1990s.* Dublin: Stationery Office.
Department of Health (1996) *Report of the enquiry into the operation of Madonna House.* Dublin: Government Publications.
Department of Health (1996) *Putting Children First: Discussion Document on Mandatory Reporting.* Dublin: Department of Health.
Department of Health (1997) *Putting Children First: Promoting and Protecting the Rights of Children.* Dublin: Department of Health.
Gilligan, R. and Chapman, R. (1997) *Developing Good Practice in the Conduct of Child Protection Case Conferences: An Action Research Project.* Cork: Southern Health Board.
Irish Catholic Bishop's Advisory Committee on Child Sexual Abuse by Priests and Religious (1996) *Child Sexual Abuse: Framework for a Church Response.* Dublin: Veritas.
Joint Committee on Tourism, Sport and Recreation (1998) *Protection of Children in Sport,* Dublin: Government of Ireland
41
McGuinness, C. (1993) *The Report of the Kilkenny Incest Investigation.* Dublin: Government Publications.
North Western Health Board (1998) *West of Ireland Farmer Case: Report of the Review Panel.* Manorhamilton: North Western Health Board.
Ward. P. (1997) *The Child Care Act 1991*, Dublin: Round Hall Sweet & Maxwell.
Western Health Board (1996), *Kelly — a Child is Dead.* Interim Report of the Joint Committee on the Family, Dublin: Government Publications Office.

42

Appendix 1

List of Health Board Addresses

EASTERN HEALTH BOARD

AREA CHILD CARE MANAGER

Community Care Area Address Phone No. Fax No.

Area 1 Tivoli Road
Dun Laoghaire, Co Dublin 01-2843579 01-2808785
Area 2 Vergemount Hall, Dublin 6 01-2698222 01-2830002
Area 3 The Malting Business Pk
54/55 Marrowbone Lane
Dublin 8 01-4544826 01-4544827
Area 4 Old County Road
Crumlin, Dublin 12 01-4542511 01-4542122
Area 5 The Lodge
Cherry Orchard
Ballyfermot, Dublin 10 01-6268101 01-6268281
Area 6 Rathdown Road, Dublin 7 01-8680444 01-8821208
Area 7 Aras Daibhin
Jones's Road, Dublin 3 01-8552000 01-8554136
Area 8 Cromcastle Road
Coolock, Dublin 5 01-8476122 01-8479944
Area 9 O'Donegans
4 New Road
Newbridge Road, Naas
Co Kildare 045-881974 045-881975
Area 10 Glenside Road, Wicklow 0404-68400 0404-69044
43

MIDLAND HEALTH BOARD

AREA CHILD CARE MANAGER

Community Care Area Address Phone No. Fax No.

Longford/ Health Centre
Westmeath Mullingar
Co Westmeath 044-40221 044-39170
Laoise/Offaly Health Centre
Tullamore
Co Offaly 0506-41301 0506-21136

MID-WESTERN HEALTH BOARD

AREA CHILD CARE MANAGER

Community Care Area Address Phone No. Fax No.

Limerick Vocational Training Services
Dooradoyle
Limerick 061-482792 061-482471
Clare Tobartaoiscain
Ennis 065-23155
Co Clare 065-23156 065-43952
North Tipperary General Hospital
Nenagh
Co Tipperary 067-31491 067-41357
44

NORTH-EASTERN HEALTH BOARD

AREA CHILD CARE MANAGER

Community Care Area Address Phone No. Fax No.

Cavan/ Health Care Unit
Monaghan Monaghan 047-30400 047-84587
Louth Community Care Office
Dublin Rd
Dundalk
Co Louth 042-9332287 042-9333814
Meath Family Resource Centre
Commons Road
Navan
Co Meath 046-73178 046-73183

NORTH-WESTERN HEALTH BOARD

AREA CHILD CARE MANAGER

Community Care Area Address Phone No. Fax No.

Donegal Ballybofey
Co Donegal 074-31391 074-31983

Sligo/ Markievicz House
Leitrim Sligo 071-55177 071-55131
45

SOUTHERN HEALTH BOARD

AREA CHILD CARE MANAGER
Community Care Area Address Phone No. Fax No.
South Lee Abbey Court House
George's Quay, Cork 021-923814 021-963822
North Lee Abbeycourt House
Georges Quay
Cork 021-965511 021-963822
North Cork Hibernian Way
Bank Place
Mallow, Co Cork 021-30200 021-42504
West Cork Hibernian Buildings
Main St
Skibbereen, Cork 028-23141 028-23172
Kerry 18 Denny St
Tralee, Co Kerry 066-20300 066-81480
46

SOUTH-EASTERN HEALTH BOARD

AREA CHILD CARE MANAGER
Community Care Area Address Phone No. Fax No.
Carlow/Kilkenny Community Care Centre
James Green
Kilkenny 056-52208 056-64172
Waterford Community Care Centre
Cork Road
Waterford 051-842800 051-843688
Wexford Community Care Centre
Grogan's Road
ACC Building
George's St 053-65112
Wexford 053-65113 053-23394
South Tipperary Community Care Centre
Western Rd
Clonmel
Co Tipperary 052-77000 052-25337
47

SOUTH-EASTERN HEALTH BOARD

AREA SOCIAL WORK MANAGER
***Community Care Area* Address Phone No. Fax No.**
Carlow/ Patrick St
Kilkenny Kilkenny 056-52208 056-62741
Waterford Community Care Centre
Cork Road
Waterford 051-842800 051-843688
Wexford South Eastern Health Board
Ely House 053-47718
Wexford 053-47719 053-47706
South Tipperary Community Care Centre
Western Road
Clonmel
Co Tipperary 052-22011 052-25337

WESTERN HEALTH BOARD

AREA CHILD CARE MANAGER
Community Care Area Address Phone No. Fax No.
Galway Community Care Offices
25 Newcastle Road 091-523122
Galway ext. 6228 091-524231
Mayo Co Clinic
Castlebar 094-22333
Co Mayo ext.2183 094-27106
Roscommon HB Offices
Lanesboro St
Roscommon 0903-26732 0903-26732

Appendix 2
Suggested Template for a Standard Reporting Form for Reporting Child Protection and Welfare Concerns to a Health Board

1. Date of Report:
2. Name of person reporting:
3. Address of person reporting:
4. Relationship of reporting person with the child concerned
5. Method of Report (telephone call, personal call to office):
6. FAMILY DETAILS
Details of child concerned
Surname
Forename
D.O.B.
Male/female
Alias (known as)
Address:
Correspondence address (if different)
Telephone number
49
7. State whether you consider your report to indicate (a) suspected or actual child abuse or (b) need for family support, giving reasons
Physical Sexual Emotional
Abuse Abuse Abuse Neglect
Suspected o o o o
Actual o o o o
8. Details of other family members/household members
NAME AGE RELATIONSHIP EMPLOYMENT/ LOCATION
TO SCHOOL
CHILD
In cases of emergency, or outside health board hours, reports should be made to An Garda Sı ´ocha´na.
9. Name of other professionals involved with child/ren and/or parents/carers.
Public health nurse:
School:
General practitioner:
Any other agency or professional involved (please describe the nature of any involvement):
50
10. REPORT DETAILS
Describe, as fully as possible the nature of the problem or incident being reported, giving details of times and dates of individual incidents, the circumstances in which they occurred, any other persons who were present at the time, and their involvement:
11. Has any explanation been offered by the child, and/or parents/carers, which would account for the current problem or incident? (Details)
12. As far as possible, describe the state of the child/ren's physical, mental and emotional well-being
13. If child abuse is being alleged, who is believed to be responsible for causing it?
Include (if known)
Name:
Address:
Degree of contact with child:
Degree of contact with other children:
14. Describe (in detail) any risks to which the child/ren in this situation

are believed to be exposed
15. How did this information come to your attention?
16. What has prompted you to report your concern at this time?
51
17. What evidence of harm exists at present?
18. Are there any factors in the child and/or parents/carers' present situation, which may have relevance to the current concern? (for example, recent illness, bereavement, separation, addiction, mental health problem or other difficulty)
19. Are there any factors in the child and/or parents/carers' situation which could be considered protective or helpful (for example, extended family or community support).
20. Has any action been taken in response to the current concern or incident/ (Details)
21. Are the child's parents/carers aware that this concern is being reported to the health board?
22. Is there a need for urgent protective action at this point?
23. Any other comments

SIGNED

DATE:
52

APPENDIX 9

PRISON/COMMUNITY TRANSFER OF INFORMATION FORM

(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

PRISON/COMMUNITY TRANSFER OF INFORMATION FORM

This form must be faxed from the dispensing pharmacist in the community to the healthcare staff in the prison and vice versa as appropriate, before a new prescription is written or the next dose of methadone /medicines is administered.

Client Name	DOB	Prison/Clinic	Methadone dose (in words and figures)	Date last dose dispensed	Other medication	Date last dispensed

Confirmed by:

Name: ________________ Signature: ____________________________
Pharmacist/RGN/RPN/MO/GP

Date: ______________

This form must be retained as per HSE/IPS policy.

APPENDIX 10

HSE SERVICE PROVIDER (DTC/SATELLITE) CONTACT DETAILS

(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

HSE SERVICE PROVIDER (DTC/SATELLITE) CONTACT DETAILS

Community Services Contact Details – Dublin Area

Dublin Area	**GP Co-ordinator**	**Contact details**	**Chief Pharmacist**	**Contact details**
NAHB	Dr Des Crowley	087 2198094	Nihal Zayed 2nd Floor PhibsboroTower Dublin	087 2252860 01 8820309/327 nihal.zayed@mailc.hse.ie
SWAHB	Dr Margaret Bourke	086 8177112	Denis O'Driscoll Bridge House Cherry Orchard Hospital Ballyfermot Dublin 10	087 2904852 denis.odriscoll@mailf.hse.ie
ECAHB	Dr Cathal O'Sullivan	087 2937570	Helen Johnston Centenary House Dun Laoghaire Co. Dublin	086 8543733 01 2803335 helen.johnston@maild.hse.ie

METHADONE DISPENSING CLINICS

Clinics East Coast Area of Dublin mid- Leinster.

Drug Treatment Centre	Opening Hours for pharmacy	Fax Number	Tel number	E-mail of pharmacists
Patrick Street, 99 Patrick St. Dun Laoire Co. Dublin	8.45- 12.30 & 2.00- 2.30 Weekdays only	01 2841169	01 2301901	deirdre.hickey@maild.hse.ie
Baggot Street, 19 Haddington Road, Dublin 4.	8.45- 11.30 Weekdays & 10.00- 11.30 Weekends	01 6603227	As fax, or 01 6699500 when pharmacy is closed	rina.bacik@maild.hse.ie mairead.tobin@maild.hse.ie
Killarney Road, Drug Treatment Centre, Killarney road, Bray, Co. Wicklow.	9.00- 11.45 every day & 2.00- 3.45 on weekdays only.	01 2022897	012762918	john.kingston@maild.hse.ie

Satellite Clinics where there is no pharmacy.

Drug Treatment Centre	Opening Hours for pharmacy	Fax Number	Tel number	E-mail of pharmacists
Fassaroe, Little Bray Family Resource Centre, Ard Chulann, Fassaroe, Bray, Co. Wicklow.	Tues & Thursday 5.00- 7.00 pm		Dr. Moloney	For contact details, which must not be given to clients, please phone: Chief pharmacist 086 8543733 helen.johnston@maild.hse.ie or GP co-ordinator 0872 2937570 cathal.osullivan @ maild.hse.ie
Lincara Centre, Boghall Road, Bray, Co. Wicklow.	Tues & Thursday 7.30- 9.30 pm		Dr. Moloney	
Mounttown In Patrick St Clinic	Mon & Wed 2.00- 3.30		Dr Quinn	
Sallynoggin Health Centre, Lower Glenageary Road,Dun Laoire.	Monday 8.00- 9.30 pm & Wed, Thurs. 5.30- 7.00 pm		Dr Savage	
Dundrum Health Centre, Dublin 14.	Tues & Thursday 6.00- 7.30 pm		Dr Mc Govern	
Loughlinstown Clinic, St Columcille's Hospital, Loughlinstown, Co. Dublin.	Tues & Thursday 11.00- 1.00		Dr Ryan	
St. Cronan's In Killarney Road Clinic	Mon & Wed 5.30- 7.00		Dr Quinn	

NORTHERN AREA HEALTH BOARD

Clinic	Opening Hours	Phone No.	Pharmacist	Mobile No./Fax
DISPENSING CLINICS				
City Clinic, 108 Amiens St. Dublin 1 City Clinic, 109 Amiens St. Dublin 1	Mon to Fri 9.00-12.00 and 2.00-3.30 5.00-6.30pm Sat/Sun 9.30-12. Mon-Fri 9.00-12.00 and 2.00-3.30 Evening Prog. Mon-Fri 5.00-6.30 Sat/Sun 9.30-12.00	01-8555310 01-8555311 01-8555313 As Above	Siobhan Herron	086-8634879 01-8555314 086-8848646 087-6294479 01-8555314
Domville House, Ballymun Rd. Dublin 11	Mon to Fri 9.00-12.00 and 2.00-3.30 Mon to Fri 5.00-6.30 Sat/Sun 9.30-12.00	01-8620111 01-8620298 01-8620299 Direct Lines: 01-8579901/7 01-8579901	Sonya Sanchez Michael Barrett Danny Carroll Deirdre Devine	01-8620297
Mobile Bus, St. Marys Hospital, D.8	Mon to Fri 9.15 - 4.15 Sat/Sun: 9.15-3.15	087-2497420 01-6207094 (St. Marys Hospital)	Ismail Kajee	01-6207090
The Mews, 224 N.C.R., Dublin 7	Mon to Fri 9.00-12.00 2.00 – 3.30(Weds only) 5 – 6.30 (Weds only) Sat/Sun 9.30-11.30	01-8383852 01-8383794 Direct Line: 01-8823625	Brid Powell Pauline Reilly	01-8384830
Wellmount Clinic, Wellmount Health Centre, Wellmount Pk, Finglas, D.11	Mon to Fri 5.15 – 6.30 Sat/Sun 9.30-10.30	01-8346119 Direct Line: 01-8827780	Paulina O'Hanlon	01-8567702
Darndale Clinic, Beldale View, Old Camp Lane, Darndale, D.17	Mon to Fri 9.00-12.00 and 2.00-3.30 Sat/Sun/Bank Hols 9.00-10.30	01-8488951	Barry Flood	01-8488959
Tolco, Cabra, D.11	Mon –Fri: 9 -12 2 – 3.30 5 – 6.30 Sat/Sun 9.30 - 11	01-8301349	Pauline O'Hanlon	01-8301349

Satellite Clinics

Ballymun Health Centre, Ballymun, D.9	Mon 5.30 – 7.00	01-8420011		01-8831289
Barry Centre, Unit 3, Barry Shopping Ctr, Finglas West, D.11	Mon/Wed/Thur 9.30-12.45	01-8643811	Richard	01-8643835
Blanchardstown Mobile Clinic, JCM Hospital, D.15	Mon/Tue/Wed 2.00-5.30	087-2497420	Ismail	01-6207090

Bonnybrook c/o Bonnybrook Youth Resource, Glin Rd, D.17	Wed/Fri 10.00-11.30	01-8489308		No Fax Machine
Coolock Health Centre Cromcastle Rd, Coolock, D.5	Tue 9.00-12.00			
Corduff Health Centre, Corduff, D.15	Fri 2.00-5.00	01-8211131		01-8211136
Donnycarney Drugs Project, Collins Ave East, D.5	Mon 1.00-3.00	01-8328040		01-8512272
Edenmore Health Centre, D.5	Fri 8.00 – 10.00	01-8480666		01-8473903
Kilbarrack Health Centre, Foxfield Crescent, D.5	Tue/Thur/Fri 2.00-5.00	01-8391221		01-8399556
Mulhuddart Clinic, 10 Dromheath Ave., D.15		01-8208440		Fax same as phone number. Fax machine not working.
Swords Health Centre, Bridge St, Co. Dublin	Tue 5.00-7.00	01-8902200		01-8902121
Thompson Centre, 53 Mountjoy St., Dublin 1	Mon 10.00-1.00	01-8601174		
Howth Health Centre, Co. Dublin	Tue 5.00-7.00	01-8322984		01-8395717
North Road, Finglas, D.11	Wed 3.30-5.30			
Trinity Court, 30/31 Pearse St, D.2	Mon to Fri 9.30-12.30 and 2.30-4.30	01-6488600	Pharmacist on duty	01-6488700 (main reception fax)

SOUTH WESTERN AREA HEALTH BOARD

Clinic	Opening Hours	Phone No.	Pharmacist	Mobile No./Fax
Mobile Bus. Tallaght Hosp. Grounds (As Belgard Rd.)	10.00-12.00 and 2.00-3.00	01-4513745 01-4513894	Brian Cronin	086-8286680 01-4513735
Aisling Clinic, Ballyfermot Dublin 10	9.00-12.00 2.00-4.00 5.00-7.00	01-6206012	Gordon Ryan Ciara Stack	01-6206011
37 Castle St., Dublin 2	Mon to Fri 9.00-12.15 and 2.00-4.00	01-4767029	Blaithin Cotter	01-6778139
Cork Street, D.8	Mon to Fri 10.00-12.00 Sat/Sun 10.00-11.00	01-4544933 01-4544940	Jo McDonagh	01-4544946
Curlew Rd., Drimnagh, D.12	Mon to Fri 9.30-12.30	01-4556422	Marie Dunne	01-4550645
Dr. Steevens Clinic Dublin 8	Mon to Fri 9.00-12.00 and 2.00-4.00 Sat/Sun 11.00-12.30	01-6352530	Shaun Doyle	01-6352076
Fortune House (Detox Ctr) Ballyfermot, D.10	Mon to Fri 9.00-12.00 and 2.00-2.30	01-6206036	Gordon Ryan Majella Stack	01-6206031
Inchicore Health Centre, Emmet Road, Dublin 8	Mon to Fri 12.30-1.30 and Sat/Sun 10.30-11.30	01-4531978		01-4544574
Irish Town Health Ctr., Dublin 4		01-6608629		01-6683906
Millbrook Lawns, St. Dominics S.C. Dublin 24	Mon to Fri Starts at 5.30	01-4525066		
The Lodge Old County Rd, Crumlin, D.12	Mon to Fri 10.00-12.00 and 2.00-4.00	01-4154817	Roweta Hussein	01-4154818
JADD, Fortunestown Lane, Jobstown, Tallaght, D.24	Mon to Fri 2.30-4.30 Sat/Sun 10.00 11.00	01-4630656	Pharmacist/ Nurse on duty	01-4597639
CASP, Ballyowen Meadows, Fonthill Rd, Clondalkin, D.22	Mon to Fri 4.30-6.00 Sat/Sun 10.00-11.00	01-6166236		01-6166755
Belgard rd, Tallaght Dublin 24	As Mobile Bus, Tallaght	01-4513894	Brian Cronin	01-4513735

NATIONAL CONTACT DETAILS:

AREA	Contact person:	Contact details
HSE North Western Area (Sligo, Leitrim, South Donegal and West Cavan)	Ms. Trish Garland HSE West Addiction Service Charter House Old Market Street Sligo Donegal is covered by Moira Mills, Alcohol & Substance Advisory Service, Eunans Court, Letterkenny.	Tel: (071) 9140409 Fax: (071) 9140412 Tel: (071) 9140409
HSE North Eastern Area (Louth, Meath, Cavan, Monaghan)	Ms. Lesley O'Sullivan Drug Services Facilitator HSE Dublin North East Primary, Community and Continuing Care St Brigids Complex, Kells Road, Ardee, Co. Louth Ms. Joanne O'Brien, Unit Liaison Pharmacist, HSE Dublin North East, Railway St, Navan, Co. Meath	Tel: (041) 6850671 Tel: (046) 90764351 Tel: (087) 2704823
HSE Southern Area (Cork and Kerry)	Mr. Willie Collins, Co-ordinator Drugs & Alcohol Services, St. Finbar's Hospital, Douglas Road, Cork. Dr. Declan O'Brien, Arbour House, St Finbar's Hospital, Douglas Road, Co. Cork. Dr. Catherine Murphy, HSE Southern Area, Floor 2, Abbey Court House, George's Quay, Cork.	Tel: (021) 4966555 Tel: (021) 4968933 Tel: (021) 4965511
HSE South Eastern Area (Wexford, Waterford, Kilkenny Carlow and Tipperary South Riding i.e. Tipperary Town, Cashel, Cahir and Carrick-on-Suir)	Mr Tony Barden, Regional Drug Co-ordinator. Catherine Lawlor, Co-ordinator of Substance Misuse Carlow and Kilkenny.	Tel: (051) 846720 Tel: (056) 7784638
HSE Midland Area Laoise, Offaly, Westmeath and Longford.	Fran Byrne, Regional Administrator, Community Alcohol & Drug Service, St. Loman's Hospital, Mullingar, Co. Westmeath	Tel: Mob: (086) 3802612 Or (044) 84352
HSE Western Area Mayo, Galway and Roscommon	Ms. Fiona Walsh, Drugs Co-ordinator, 64 Dominic Street, Galway	Tel: (091) 561198
HSE Mid Western Area Clare, Limerick and Tipperary North Riding i.e. Thurles Roscrea and Nenagh	Mr. Rory Keane, A/Co-ordinator, Limerick Drug and Alcohol Service, Unit 4, Richmond Court, Mount Kenneth, Dock Road, Limerick.	Tel: (061) 483572 or Tel: (087) 2464393

APPENDIX 11

IPS SURGERY CONTACT DETAILS

(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

Prison	Phone	Fax
Mountjoy Medical Unit	01 8062915	01 8062915
Mountjoy Main Surgery	01 8858953/8819/8967	01 8062859
Dochas Centre	01 8858975	01 8062963
Cloverhill Medical Unit	01 6034686/90	01 6304688
Wheatfield Medical Unit	01 6209434/39 or 01 6209480	01 6209461
St. Patrick’s Institution	01 8062905	01 8307705
Midlands Prison	057 8672131	057 8672134

APPENDIX 12

APPLICATION FOR A COMMUNITY TREATMENT PLACE

(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

APPLICATION FOR A COMMUNITY TREATMENT PLACE

I wish to apply for a Community Drug Treatment Place for:

Patients Name: ________________________________

Address: ____
____

Date of Birth: __________________________________

Prison: _______________________________________

Pris No.: ______________________________________

Expected Date of Release: _______________________

Prescribing Doctor: _____________________________

Medical Notes: ____
____
____
____
____
____
____
____
____
____
____

To be completed by Community Drug Treatment Service

Patient _______________

- **Will have a treatment place in ________________ Centre/Clinic**
- **Will not have a treatment place on the date of his/her release**

Signed: ___________________ **Date:** __________________

APPENDIX 13

CTL ENTRY/EXIT FORM
(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

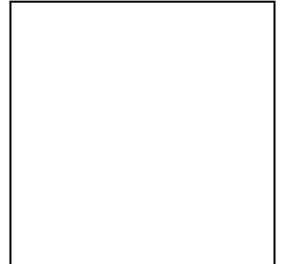
CENTRAL PATIENT TREATMENT LIST – ENTRY FORM

On receipt of completed form, the patient will be entered on the Central Patient Treatment List. This list may be checked by telephoning 01 677 1500.
All information on this form should be filled in **BLOCK LETTERS.**
THE FORM SHOULD BE FILLED IN FULL
Treatment card cannot be processed without **PATIENT SIGNATURE & PHOTOGRAPHS**
COMPLETED FORMS TO BE RETURNED TO F RAFFERTY AT TRINITY COURT 30/31 PEARSE STREET

PATIENT DETAILS

SURNAME: ____________________

INSERT PHOTO



FIRST NAME: ____________________

ADDRESS: ____________________

____

DATE OF BIRTH: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

PATIENT GMS NO: ☐☐☐☐☐☐☐☐☐☐

TREATMENT DETAILS

COMMENCEMENT DATE: DAY ☐☐ MONTH ☐☐ YEAR ☐☐ **DAY DUE TO FINISH:** DAY ☐☐ MONTH ☐☐ YEAR ☐☐

(TICK WHERE APPROPRIATE)
DETOXIFICATION: ☐ **MAINTENANCE:** ☐ **STABILISATION:** ☐

DISPENSING REQUIREMENTS: ____________________

____

DOCTOR/AGENCY NAME: ____________________

ADDRESS: ____________________

____

STAMP MAY BE USED

TELEPHONE NO: ____________________

DOCTORS GMS NO: ☐☐☐☐☐

PHARMACY NAME: ____________________

ADDRESS: ____________________

____

STAMP MAY BE USED

TELEPHONE NO: ____________________

PHARMACY GMS NO: ☐☐☐☐☐

CENTRAL PATIENT TREATMENT LIST – EXIT FORM

All information on this form should be filled in **BLOCK LETTERS**.
THE FORM SHOULD BE FILLED OUT BY PRESCRIBING DOCTOR ONLY
PLEASE RETURN COMPLETED FORMS TO **THE CENTRAL PATIENT TREATMENT LIST,** 30/31 PEARSE STREET, DUBLIN 2

PATIENT DETAILS

SURNAME: ______________________________

FIRST NAME: ______________________________

DATE OF BIRTH: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

TREATMENT CARD NUMBER: PH ☐☐☐☐

EXIT DETAILS

EXIT DATE: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

(TICK ONE BOX ONLY)

TRANSFER TO OTHER GP/AGENCY ☐

TREATMENT SUCESSFULLY COMPLETED ☐

TREATMENT FAILURE ☐

DOUBLE SCRIPTING ☐

NO CONTACT FOR ONE MONTH ☐

BARRED ☐

R.I.P. ☐ **DATE R.I.P.:**________________

PRISON (ONE MONTH) ☐

HOSPITAL (ONE MONTH) ☐

OTHER: ☐

(PLEASESTATE:)______________________________

DOCTOR/AGENCY NAME: ______________________________

ADDRESS: ______________________________

______________________________ **STAMP MAY BE USED**

SIGNATURE: ______________________________

(TICK APPROPRIATE BOX)

PHARMACY NOTIFIED: **YES** ☐ **NO** ☐

CARD RETRIEVED FROM PHARMACY: **YES** ☐ **NO** ☐

APPENDIX 14

JOINT IPS/HSE ARRANGEMENTS FOR THE SUPPLY OF METHADONE TO PRISONERS ON CHRISTMAS/NEW YEAR TEMPORARY RELEASE

(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

Information for all prison surgery staff:

1. All patients on Methadone treatment will be assigned to a clinic, prior to release.

2. The relevant sections of the **Prison Release Form must be completed**, for each patient, by healthcare staff.

This states:

- Patient details
- Date of release
- Date of return
- Clinic/G.P. details
- Dose of Methadone and confirmation of last dose given
- Any other medication, if any, the patient has been prescribed. The clinics will dispense this medication to the patient, as long as they have same in stock. (They usually have most anti-depressants, hypnotics etc in stock).

3. **This form must then be faxed to the relevant clinic.**

4. **Patients are NOT TO BE GIVEN their daily dose of Methadone in the surgery on the day of their release.**

5. A letter to confirm patient identification must then be prepared. This must be on headed prison paper, and should be in the format outlined i.e. include:

- Patient photograph - this can be printed from PRIS, cut out and attached to the page.
- This must then be signed across, in red pen, by a member of surgery staff.
- Patient name, and assigned clinic details.
- This letter is then given to the patient. This letter must be taken to the clinic, to confirm patient I.D. and will be retained by the clinic.

6. All patients **must attend their respective clinics on the day of release** to have their Methadone dispensed by the pharmacist/nurse. Those patients attending clinics in SWAHB and ECAHB will also be required to see the doctor on the day of release.
Methadone will be dispensed in the clinic on the day of release.

7. **On the last day of T.R., the dose of Methadone will be given in the clinic.** Please ensure that all patients are aware of this, as they will not be dispensed Methadone on their return to prison.

8. On the day of return, the relevant sections of the form will be completed by the Pharmacist/Nurse and this form will then be faxed back to the prison surgery.

IPS Healthcare Directorate. Date: 13th December 2005

APPENDIX 15

AUDIT REPORT OF UNPLANNED ARRIVAL AT COMMUNITY SERVICES

(Policy 26: Liaison and Transfer Arrangements Between Community and Prison Treatment Services)

Prison to Community Transition Arrangements for Prisoners on Methadone Maintenance **Incident Report**
Clinic Name:___________________________________ **Address:** ____________________________________ ____________________________________ **Telephone Number:** __________________________ **E-Mail address:** ___________________________ **Contact person in Clinic:** __________________________
Client Name: __________ **Address:** ____________________ _________________________ **Date of birth:** ____________________
Name of prison from which client released:
Brief summary of the situation as faced by the clinic:

Please email copy to Julian.Pugh@mailf.hse.ie, mob: 086 8299201, fax 01 6201601
And email copy to Chief Pharmacist

APPENDIX 16

METHADONE: DRUG INTERACTIONS

Drug	Effect	Mechanism
Alcohol	Increased sedation, respiratory depression	Additive CNS effect
Benzodiazepines	Enhanced sedative effect	Additive CNS depression
Tricylic Antidepressants	Enhanced sedative effect	Additive CNS depression
Other opiates	Enhanced sedative effect and respiratory depression	Additive CNS depression
Zopiclone(Zimovane, Zileze, Zopitan)	Enhanced sedative effect	Additive CNS depression
Barbiturates (including Phenobarbitone)	Reduced methadone levels, increased sedation	Stimulation of hepatic enzymes involved in methadone metabolism by barbiturates
Carbamazepine	Reduced methadone levels	Stimulation of hepatic enzymes involved in methadone metabolism by carbamazepine
Phenytoin	Reduced methadone levels	Stimulation of hepatic enzymes involved in methadone metabolism, by phenytoin
Urine acidifers	Reduced methadone plasma levels	Raised urinary excretion of methadone
Cimetidine	Possible increased methadone levels (few cases reported)	Inhibition of hepatic enzymes by cimetidine
Drug	**Effect**	**Mechanism**

Erythromycin	Increased methadone levels expected	Decreased methadone metabolism
Fluconazole	Raised methadone levels	Decreased methadone metabolism
Ketaconazole	Raised methadone levels	Decreased methadone metabolism
Urine alkalanisers e.g. sodium bicarbonate	Increased methadone levels	Reduced urinary excretion of methadone
Grapefruit juice	Raised methadone levels	Decreased methadone metabolism
Buprenorphine	Antagonist effect or enhanced sedative and respiratory depression	Partial agonist of opiate receptors
Cisapride	May cause QT interval prolongation	Increased risk factor for QT prolongation – monitor
Cisapride, domperidone, metoclopramide	May increase speed of methadone absorption, not the extent	Possibly by reversing the delayed gastric emptying associated with opioids
Fluoxetine ? Other SSRI's	Raised methadone levels	Decreased methadone metabolism
Omeprazole	Increased methadone levels possible	Possible effect on methadone absorption from gut
Nifedipine	Increased nifedipine levels, no effect on methadone levels. Significance?	Methadone increase metabolism of nifedipine
Drug	**Effect**	**Mechanism**

Rifampicin	Reduced methadone levels	Rifampicin stimulates hepatic enzymes involved in methadone metabolism
MAOI (Selegiline, Moclobemide)	CNS excitation, delerium, hyperpyrexia, convulsions, hypotension or respiratory depression. Very severe interaction with Pethidine, evidence with methadone limited	Unclear, avoid combination if possible
Indinavir (Crixivan)	Raised methadone levels	Decreased methadone metabolism
Ritonavir (Norvir)	May reduce plasma methadone levels	Effect on methadone metabolism
Lopinavir with Ritonavir (Kaletra)	May reduce plasma methadone levels	
Other protease inhibitors (Reyataz, Crixivan, Agenerase, Invirase)	May raise or lower methadone levels	Effect on methadone metabolism
Nelfinavir (Viracept)	May decrease methadone levels	
Zidovudine (Retrovir, Combivir)	Raised levels of zidovudine, possible effect on methadone, may need to increase methadone dosage	Unknown
Nevirapine	Decreased methadone levels	Increased methadone metabolism

Ref: Stockley's Drug Interactions 2007
BNF 53, March 2007