SCOTTISH PRISON SERVICE

DRUG MISUSE AND DEPENDENCE

OPERATIONAL GUIDANCE

The following Operational Guidance Manual has been prepared with input from both community and prison addictions specialists in an attempt to provide prison medical officers with a reference guide to ensure safe and consistent treatment is offered to all prisoner patients on entering custody and throughout their imprisonment period and is based on practice outlined in the current orange book "Drug misuse and dependence: UK guidelines on clinical management" (2007).

The objectives of the manual are:

- To offer advice and guidance to prison medical officers on how to safely manage prisoners with drug addiction problems throughout their custodial term
- To ensure consistent treatment is offered in different establishments to prevent interruptions to patient's treatment merely due to transfers between prisons
- To advise medical officers how to manage patients with alcohol addiction following admission to custody
- To indicate treatment options available for those prisoners seeking help for nicotine addiction.

CONTENTS

SECTION A: DRUG ADDICTION

1) Admission Procedure

Patients admitted from the community with a history of substance misuse and clinical withdrawals will provide a supervised sample of urine for drug analysis and then be offered treatment on the first night and following morning in custody as below:

1. Illicit opiates or methadone:	DHC 60mg first evening DHC 120mg following morning
2. Illicit benzodiazepines or cocaine:	Diazepam 30mg first evening Diazepam 30mg following morning

Patients using a combination of substances from both (1) and (2) above will receive both DHC and Diazepam as listed above.

Patients will be seen by a medical officer within 24 hours of admission and on the basis of patient history, clinical examination and drug urinalysis results will receive a reduction program as below:

Illicit Opiate or Methadone use:

Days 1-3:	DHC 120mg twice daily
Days 4-6:	DHC 90mg twice daily
Days 7-9:	DHC 60mg twice daily
Days 10-12:	DHC 60mg nocte

Illicit Benzodiazepine or Cocaine use:

Days 1-3:	Diazepam 30mg twice daily
Days 4-6:	Diazepam 20mg twice daily
Days 7-9:	Diazepam 15mg twice daily
Days 10-12:	Diazepam 10mg twice daily
Days 13-15:	Diazepam 5mg twice daily
Days 16-18:	Diazepam 5mg nocte

Patients using substances from both of the above will receive both components of the reduction program.

Patients can be started on any part of the reduction program based on clinical need.

In cases where the admitting nurse feels that the prisoner is presenting in an intoxicated manner no medication will be issued until assessment has been carried out by the medical officer at the next scheduled clinic.

2) Continuation of Community Prescriptions in Custody

Following assessment as above, the medical officer will make a clinical decision as to whether a community prescription of methadone or Suboxone will be continued on entering custody.

This decision must take into account numerous factors including clinical examination (presence of fresh intravenous sites), urinalysis results, BMI, duration in treatment and previous evidenced stability in community, etc.

In all cases the doctor must complete a community liaison form (Appendices 1 & 2), which will be faxed to the community prescriber on the day of consultation. This will advise the community prescriber of planned court dates/liberation dates, objective evidence of substances present on admission urinalysis, evidence of intravenous sites and planned treatment on entering custody.

Methadone should not be administered until written confirmation is received from the community prescriber indicating both confirmation of the prescribed community dose and confirmation that they will continue to provide a community prescription on release from custody. In the period between admission and conformation of prescription by the community prescriber, the patient should be offered some form of medication until they either commence a methadone prescription or reduce from treatment.

In cases where the prison doctor has made a clinical decision not to continue a community prescription, the community prescriber is invited to telephone to speak directly to the doctor should they feel that there are clinical reasons why a patient should remain on a community substitute prescription. This will allow the prison and community doctors to discuss an individual patient's care and agree on an appropriate management plan for treatment. Where a prescription is not to continue, reduction of prescription should be carried out as outlined in section 7) Reducing Doses of Methadone.

3) Methadone Dosing and Missed Methadone Doses

The recognised therapeutic range for methadone prescribing is 60 – 120mg; however some prisoners will achieve stability above or below this range. When a community dose higher than 120mg is being prescribed, clearance must first be sought from the Director of Health and Care for this to be maintained whilst in custody. If a community dose higher than 120mg is to be reduced to within the suggested therapeutic range, reduction should be carried out as outlined in section 7) Reducing Doses of Methadone.

Where a clinical decision has been made to continue methadone, but a delay in confirmation has lead to the patient missing several days of their methadone dose, a reduction in dose may be required when restarting treatment. Methadone should be reintroduced as follows:

- Missed 1 day of Methadone - Usual daily dose
- Missed 2 or 3 days of Methadone – Usual daily dose (Give as split dose = dose administered as two halves separated by at least 3 hours)
- Missed 4 or 5 days of Methadone – Reduce dose to half of usual daily dose or to a dose of 40mg (whichever is greater)
- Missed 6 or more days Methadone – Treat as new induction of Methadone

Those patients who receive a dose reduction should increase by methadone 10mg every 3 days until their usual daily dose is reached.

4) Benzodiazepine Prescribing in Custody

Benzodiazepines will not be prescribed on a maintenance basis in custody.

This is in accordance with the orange book - "Drug misuse and dependence: UK guidelines on clinical management" (2007) that benzodiazepines should be prescribed only for "severe and enduring anxiety" for a maximum period of 2 to 4 weeks. Benzodiazepines do not have a product licence for management of drug addiction.

No evidence-based guidelines have identified any reduction regimen to be superior to alternatives in terms of long-term abstinence, but evidence exists to confirm that long-term prescribing of benzodiazepines at doses of diazepam 30mg/day (or equivalent) or greater may lead to permanent cognitive impairment.

A benzodiazepine reduction should be initiated in accordance with the dosing schedule outlined in section (1) of this manual.

5) Initiation of Methadone in Custody

Patients seeking substitute treatments in custody will be assessed by the addictions team to determine suitability for treatment. Appropriate assessment including urinalysis sampling must be undertaken and individuals discussed at a multidisciplinary addictions team meeting. For those patients likely to be released on methadone, a community prescriber for continuation of methadone on return to the community **must** be confirmed in writing prior to initiation of treatment.

Where decisions have been made to initiate substitute treatment with methadone the starting dose should be between 10-40mg methadone/day and increased by no more than 10mg/week until the agreed target dose is reached.

When assessing the appropriate starting dose the following should be considered to determine the level of tolerance likely to be expected for an individual patient:

Methadone 30mg = Dihydrocodeine 300mg = heroin 0.5g (4 x £10 bags)

6) Detoxification with Suboxone

If following addictions assessment the multidisciplinary team determines that a detoxification regime is more appropriate for an individual then sublingual Suboxone should be used. A reducing dose schedule is given on appendix 5 of this guideline.

7) Reducing Doses of Methadone

Patients who choose to undergo a structured reduction of their methadone in custody should negotiate an agreed rate of reduction with their prescriber. A suggested reasonable rate would be a dose reduction of 5 – 10 mg methadone per fortnight, including for those prisoners who are being reduced from methadone for clinical reasons i.e. the risks of continuing with treatment outweigh the benefits.

When a patient reaches a daily methadone dose of 30 mg per day or less, consideration should be given to completing the reduction program by utilising sublingual Suboxone at the dosing schedule suggested in Appendix 5. This allows a

patient to complete their reduction at a faster rate than continuing with methadone dose reduction as suggested.

N.B. If converting patients from methadone to Suboxone the prescriber should ensure that 36 hours has passed between the last methadone dose being administered and buprenorphine being commenced in order to prevent precipitated withdrawals.

8) Maintenance of Suboxone

If a clinical decision is made to commence Suboxone as a maintenance treatment for opiate addiction a community prescriber must be identified in writing in the same manner as would be carried out for initiation of methadone treatment. A suggested method of initiation of treatment would be:

- Day 1 Suboxone 2mg BD (4 hours between doses)
- Day 2 Suboxone 4mg BD (4 hours between doses)
- Day 3 Suboxone 8mg BD (4 hours between doses)
- Day 4 onwards Suboxone 16mg once daily

In all cases of Suboxone maintenance patients should not receive methadone for a period of at least 36 hours before initiating treatment and they should not use heroin/opiates for a period of at least 12 hours before commencing treatment. This is to avoid the likelihood of precipitated withdrawals due to commencement of Suboxone.

9) Home Leave Methadone or Suboxone

Patients who are receiving methadone or Suboxone on a supervised basis in custody will require a community pharmacist to be identified for collection of their prescription during periods of home leave. The protocol for arranging this is attached at Appendix 6 along with the form required to be faxed/posted to the pharmacy identified.

10) Use of Naltrexone in Custody

Following addictions assessment there may be a group of patients for whom opiate blockade in the form of naltrexone is felt to be the most appropriate treatment option. Prior to commencing naltrexone all patients must have liver function tests checked and treatment should only be considered if alanine aminotransferase (AST) and aspartarte aminotransferase (ALT) levels are less than three times the upper limit of the laboratory reference range.

Following initiation of treatment liver function tests must continue to be monitored at appropriate intervals and treatment must be discontinued should the AST or ALT values exceed the above levels.

Before commencing treatment a patient should be opiate free for a minimum period of seven days and should have a supervised urinalysis sample checked prior to initial administration of treatment to confirm an opiate negative state. The first daily dose should be naltrexone 25mg followed by a usual daily dose of naltrexone 50mg thereafter.

The duration of treatment of naltrexone should be between 3 and 12 months according to patient progression and confidence.

11) ECG Monitoring for High-Dose Methadone Treatment

In accordance with Medicines and Healthcare products Regulatory Agency recommendations "Current Problems in Pharmacovigilance", volume 31, (2006) all patients on methadone doses in excess of 100mg daily should have QTc interval measurements carried out. This is due to reports of QTc prolongation and torsades de pointes associated with high-dose methadone prescribing.

Consideration of QTc monitoring should also be given to patients receiving methadone treatment where other risk factors for QTc prolongation exist (sor example, antipsychotic medications, electrolyte abnormalities, etc)

QTc intervals in excess of 440msec (males) and 470msec (females) should result in discontinuation of methadone treatment along with a full cardiac investigation, consideration of specialist referral and identification of other QTc prolongation risk factors.

Appendix 1

HMP / YOI _____
Tel: _____
Fax: _____

Dear Dr

NAME:_____ **DOB:**_____

ADDRESS:_____

The above patient was admitted on_____
This patient is in custody until_____

The patient advises that you are currently prescribing the following medications:

_____
_____

The patient states current illicit drug use is:

_____	IVDU	YES/NO
_____	IV Sites present	YES/NO

Admission Urinalysis:	Methadone	Positive/Negative
	Opiates	Positive/Negative
	Benzodiazepines	Positive/Negative
	Cocaine	Positive/Negative

Other relevant information:

_____
_____
_____

In view of the above findings and overall clinical presentation it is my intention to continue this patient's prescribed medication as stated above (except diazepam). In order to do so I require you to confirm the patient's current prescriptions by completing this form and returning to the fax number above, or by telephoning the prison at the above contact number
Yours Sincerely

DR _____
MEDICAL OFFICER HMP _____

Has ECG been carried out due to Methadone Dosage? YES/NO
Please confirm any prescriptions that you are currently issuing and that you will continue to prescribe upon release along with any other relevant information:

_____
_____

Prescriber
Signature_____Print_____Date_____

Appendix 2

HMP / YOI _____
Tel: _____
Fax: _____

Dear Dr

NAME:_____ **DOB:**_____

ADDRESS:_____

The above patient was admitted on_____
This patient is in custody until_____

The patient advises that you are currently prescribing the following medications:

_____
_____

The patient states his current illicit drug use is:

_____	IVDU	YES/NO
_____	IV Sites present	YES/NO

Admission Urinalysis:	Methadone	Positive/Negative
	Opiates	Positive/Negative
	Benzodiazepines	Positive/Negative
	Cocaine	Positive/Negative

Other relevant information:

_____
_____
_____

In view of the above findings and overall clinical presentation it is my intention to discontinue this patient's prescribed medication and commence a detoxification program of Dihydrocodeine and Diazepam.

Should you feel that there are clinical reasons why your patient should remain on their community prescription please feel free to contact me at the establishment on the above telephone number so we can discuss their management further

Yours Sincerely

DR _____
MEDICAL OFFICER HMP _____

Appendix 3

Detoxification with Suboxone:

Day 1:	Suboxone 4mg sublingually in am followed by further dose of Suboxone sublingually 4 hours later if no withdrawal symptoms have been precipitated
Day 2:	Suboxone 8mg sublingually followed by further dose of Suboxone 8mg sublingually 4 hours later
Days 3-6:	Suboxone 16mg sublingually once daily
Days 7-8:	Suboxone 14mg sublingually once daily
Days 9-10:	Suboxone 12mg sublingually once daily
Days 11-12:	Suboxone 10mg sublingually once daily
Days 13-14:	Suboxone 8mg sublingually once daily
Days 15-16:	Suboxone 6mg sublingually once daily
Days 17-18:	Suboxone 4mg sublingually once daily
Days 19-20:	Suboxone 2mg sublingually once daily

For those wishing to commence maintenance naltrexone following completion of the Suboxone reduction program there is no need to have an abstinence period and treatment can be commenced on the following day (Day 21).

SECTION B: ALCOHOL ADDICTION

Patients admitted with a history of alcohol abuse and clinical evidence of alcohol withdrawal syndrome (tachycardia, sweating, tremor, etc) should receive a fixed reduction benzodiazepine schedule as below.

Prescribers may use either diazepam or chlordiazepoxide dosing regimes. The decision may be influenced by prescriber experience and preference, and also by the ability of the establishment to administer chlordiazepoxide on a supervised basis four times daily.

1. **Diazepam Reduction:**

Days 1 and 2:	Diazepam 20mg BD
Days 3 and 4:	Diazepam 15mg BD
Days 5 and 6:	Diazepam 10mg BD
Days 7 and 8:	Diazepam 5mg BD

2. **Chlordiazepoxide Reduction:**

	Morning	Lunchtime	Evening	Night
Day 1	30mg	30mg	30mg	30mg
Day 2	30mg	20mg	20mg	30mg
Day 3	20mg	20mg	20mg	20mg
Day 4	20mg	10mg	10mg	20mg
Day 5	10mg	10mg	10mg	10mg
Day 6	10mg	10mg	-	10mg
Day 7	-	-	-	10mg

All patients receiving treatment for alcohol problems should receive vitamin supplementation:

- Thiamine 300mg daily for 1 month

Patients who are felt to be suffering from overt Delirium Tremens should be transferred to hospital for further assessment and in-patient treatment

All patients treated acutely for alcohol problems should be offered input from prison addictions services for ongoing support and throughcare arrangements for return to the community.

SECTION C: SMOKING CESSATION

Prisoners will be eligible to access various treatment options in each establishment for nicotine addiction.

Treatment will be offered in the form of nicotine replacement, which will be given as part of a package of treatment including regular motivational support meetings as outlined in "smoking Cessation Guidelines" (2009)

Treatment options will include the following (for a maximum of 12 weeks):

- NRT patches (24 Hours)
- NRT patches (16 Hours)
- Inhalator treatment
- Nicotine lozenges