

## **Updated guidance for prison based opioid maintenance prescribing**

The implementation of the Integrated Drug Treatment System (IDTS) allows for the full range of evidence based clinical interventions, including stabilisation, detoxification and maintenance, to be available across the prison estate in England.

As IDTS becomes established, it is important that the right balance be achieved in determining whether a detoxification, gradual reduction or maintenance regime is the appropriate approach when prescribing for those who are opiate dependent. DH guidance issued to support the introduction of IDTS, “Clinical management of Drug Dependence in the Adult Prison Setting” (2006) clearly sets out parameters for the use of substitute prescribing. One of the underlying principles of IDTS is that prison based treatment should be delivered in line with its community based counterpart. However, it is also important to acknowledge that illegal drugs are less readily available in a prison environment and that this should inform clinical decisions about the prescribing of substitute medication, particularly for opiate users.

There is currently some concern that maintenance prescribing is being initiated without systematic review arrangements in place as set out in the initial guidance and therefore the continuation of some prescriptions may be clinically inappropriate. One of the aims of a review is to ensure that prisoners do not remain on open-ended maintenance regimes when detoxification or a gradual reduction tailored to the individual’s need would be the more appropriate option. The purpose of this document is to restate and reinforce the original guidance to ensure that prescribing practice is in line with agreed guidelines.

Many opiate users, particularly those with longer sentences can be encouraged and supported to use their time in prison as an opportunity to achieve abstinence and this option should be discussed, and facilitated.

The option of methadone (first line) or buprenorphine maintenance after stabilisation should be considered in the following circumstances:

- where a chronic opiate user is received into custody on remand, in order to enable them to engage in treatment upon release;
- where an opiate dependent prisoner is received into custody on a sentence of less than 26 weeks, in order to enable them to engage in treatment upon release; or
- where, on the basis of a full clinical assessment, it is considered necessary to protect the prisoner on release from the risks of opiate overdose upon release.

However, prisoners should be made aware from the outset that, if they go on to receive a prison sentence of more than six months, they will be expected to work towards becoming drug free.

There is a requirement that all periods of extended prescribing whether maintenance or gradual reduction regimes are reviewed **every three months as a minimum**. The review will have input from the multi-disciplinary team including the patient, prescriber, other members of the clinical substance misuse team, CARATs, and where their involvement is incorporated within an agreed clinical governance framework, a senior officer and/or offender supervisor.

A written account of the review must be entered into the IDTS records and all options for treatment must be explored at each review. This should include the possibility of changes to clinical prescribing since many prisoners will welcome the opportunity to work towards lowering their dose of an opiate substitute whilst in prison. When a change of treatment intervention takes place and a prisoner moves from “maintenance” to a “reduction” regime, **an Activity Form must be completed** closing opioid maintenance (AF 3.2) and opening opioid detoxification more than 14 days (AF 3.3) in order to accurately capture this type of activity.

There may be occasions when prisoners on longer sentences require consideration of slower reduction of ongoing opiate substitute maintenance regimes because it is considered that any other intervention, swift reduction or detoxification, will have an adverse effect on health. Such occasions include:

- A history of injecting drug use in prison;
- A history of any serious mental health problem; or
- Impending significant events, including release, uptake of antiretroviral therapy, early period of sentence or continuing remand, transfer to another prison

Where longer term prescribing is offered to those whose sentence exceeds 26 weeks, it should be explained that at an appropriate time there will be an expectation that the prisoner works towards reducing their dose of opiate substitute medication, and that abstinence remains the ultimate goal.

At a later stage if there is some exceptional reason why abstinence cannot be considered, then the reasons for this must be clearly documented in the clinical record, at each three-month review. Maintaining a prisoner on a long-term opioid prescription should be an active decision agreed between the clinician and the patient informed by the multidisciplinary reviews.

The prisoner will also be expected to participate in the psychosocial, educational and rehabilitation opportunities available to them whilst in prison to assist them with achieving abstinence. Entry to structured drug treatment programmes and compact-based drug testing should also be discussed with the client as a care-planned progression from and towards detoxification.

Where a prisoner has been detoxified and remained drug free there may be circumstances where it would be appropriate for them to be re-inducted into opiate substitute treatment prior to release and these conditions are set out in the UK guidelines on clinical management (7.3.4.3).

It is good clinical practice to undertake regular audit of all clinical practice. The regular review of individuals on opiate substitute maintenance prescription is an excellent example of audit. The gold standard being that opiate substitute maintenance prescribing occurs in line with clear evidence based criteria with records of regular reviews, at a minimum of every 3 months and outcomes shared with patient and multidisciplinary team clearly written in notes.