CLINICAL GUIDELINES FOR WITHDRAWAL MANAGEMENT AND TREATMENT OF DRUG DEPENDENCE IN CLOSED SETTING

World Health Organization
Western Pacific Region

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WHO Library Cataloguing in Publication Data

Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings.

1. Substance-related disorders – rehabilitation. 2. Opiod-related disorders – rehabilitation. 3. Alcoholism – rehabilitation. Marijuan abuse – rehabilitation. 5. Substance abuse treatment centers. 6. Prisons. 7. Work camps. 8. HIV infections – prevention and control. 9. HIV infections – transmission. 10. Practice guideline. I. World Health Organization. Regional Office for the Western Pacific.

ISBN 978 92 9061 430 2 (NLM Classification:WM 270)

Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings

Recommendations to closed settings in the Western Pacific Region

It is anticipated that the recommendations in this document will remain valid until 2014. The HIV/AIDS and STI Focus, Division of Combating Communicable Diseases, at WHO Western Pacific Regional Office will be responsible for initiating a review of these recommendations at that time.

Acknowledgements

Many people have contributed to the development of this guidelines.
The World Health Organization (WHO), Regional Office for the Western Pacific, wishes to thank Ms Sarah Larney, Dr Bradley Mathers and Associate Professor Kate Dolan for drafting the clinical guidelines for withdrawal management and treatment of drug dependence in closed settings. Expert review of the draft was provided by Dr Alex Wodak and Dr Linda Gowing. Field-testing of the guidelines was conducted by Dr Deborah Zador and Ms Sarah Larney. The final draft was prepared by Ms Sarah Larney.

WHO would particularly like to acknowledge Dr Dominique Ricard and Mr Graham Shaw for their contribution in the field-testing of the guidelines conducted in Cambodia and in the Lao People's Democratic Republic. WHO also acknowledges Dr Fabio Mesquita, Mr Gray Sattler and Ms Manuela Moeller for their assistance in preparing the guidelines.

Declaration of interests

Conflict of interest statements were collected from all of the above major contributors. No conflict of interest has been declared by any contributors to the document.

How were the recommendations developed, reviewed, revised and finalized?

In 2005, the WHO Regional Office for the Western Pacific identified the lack of a clear direction on drug treatment in closed settings, a major problem in South East Asia. In agreement with the National Drug and Alcohol Research Centre of the University of South Wales, in Australia, WPRO requested the production of a evidence-based “Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings”.

Ms Sarah Larney, Dr Bradley Mathers and Associate Professor Kate Dolan from the National Drug and Alcohol Research Centre of the University of South Wales were requested to present a draft of the guidelines. Additional to their research and clinical experiences, search and evidence from the literature was conducted by the authors using PUBMED, the University of South Wales database, the WHO library database and regional databases. Particular efforts were made to identify systematic literature reviews and evidence related specifically to drug treatment in closed settings in developing countries, particularly from South-East Asia.

Later on the draft was submitted for review to researchers and clinicians with a strong experience and reputation in the field of drug treatment: Dr Alex Wodak and Dr Linda Gowing. The Harm Reduction Technical Officers of WPRO also made comments and directed the development according to the needs of the Member States. Comments were received and the draft amended as necessary. The amended guidelines were finally field tested in October of 2008 in Cambodia and in Lao PDR. The field-test was conducted with staff of closed settings in Lao PDR and Cambodia and further refinements were made as a result of the application on field. The final version was presented to WPRO by the end of 2008.

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Introduction

These WHO guidelines are designed to assist staff of closed settings to provide safe and effective withdrawal management and treatment services for people who use drugs in the Western Pacific Region. For the purposes of this document, "closed settings" refers to prisons, work camps, compulsory drug treatment centres and any other institution in which people are detained.

These guidelines take a *public health* approach to drug use and dependence. This approach recognises that the health of one individual affects the health of the community.

The WHO Western Pacific Regional Office recognizes that incarceration of people who use drugs is a reality in the region, despite the fact that it is not an appropriate solution for the use of drugs or health of people who use drugs. Therefore, the reality imposes the need for this transitional guidelines of appropriate drug treatment in anticipation of a better solution for the drug problem in the region.

These guidelines provide information about drugs and drug dependence; the management of drug withdrawal; and approaches to treatment for drug dependence. A training manual on the use of the guidelines has also been developed and will be available in the WHO Western Pacific Region website (http://www.wpro.who.int/sites/hsi/main.htm).

PART ONE

Understanding drug dependence and HIV

1.1 DRUG USE AND DEPENDENCE

What are drugs?

A drug is any substance (other than food) that, when consumed, causes changes in our mood or thinking processes.

Some drugs are legal, while others are illegal. Many people use legal drugs such as alcohol, nicotine (found in cigarettes) and caffeine (found in coffee and tea). Only a small proportion of the population ever use illicit drugs such as heroin or methamphetamine.

It is important to note that the legal status of a drug is unrelated to its effects or its dependence potential. People can become dependent on legal drugs just as they can on illegal drugs.

Drugs can be categorised by the effects they have on the **central nervous system** (CNS). The CNS consists of the brain and the spinal cord, and it regulates basic bodily functions such as breathing, heart beat and blood flow. All drugs affect the CNS in some way.

Stimulant drugs cause the CNS to increase activity; that is, they increase a person's heart rate and breathing. Stimulant drugs include nicotine, caffeine, amphetamine and methamphetamine, 3,4-methylenedioxymethamphetamine (MDMA, 'ecstasy', which also has hallucinogenic effects; see below) and cocaine.

Depressant drugs have the opposite effect on the CNS; they decrease a person's heart rate and breathing. Depressant drugs include alcohol, inhalants (e.g. glue, petrol, paint), benzodiazepines, heroin and other opioids such as opium and morphine. Cannabis is a depressant drug, but it also has hallucinogenic effects (see below).

Hallucinogenic drugs alter a person's perceptions. A person who has taken a hallucinogen may see or hear things that aren't real. Hallucinogenic drugs include psilocybin (found in certain types of mushrooms) and lysergic acid diethylamide (known as LSD or acid). Cannabis and ecstasy also have hallucinogenic properties.

Why do people use drugs?

Many millions of people around the world, from all walks of life, use legal and illegal drugs. The fact that a person has used drugs says nothing about their moral character. Nor does it mean that the person is drug dependent.

Different people have different reasons for using drugs. Some of the common reasons for using drugs include:

- Curiosity
- To "fit in" with friends
- Liking the way a drug makes you feel or behave
- To have more energy to do your job or study
- To block out negative feelings

Harmful drug use

Most people who use drugs do so occasionally and experience few or no negative consequences of their drug use. However, some people do experience negative or harmful consequences as a result of their drug use.

The level of harmful consequences that a person experiences as a result of their drug use varies according to the types of drugs they use, how much they use and how often they use them.

One example of **harmful drug use** is excessive alcohol consumption. A person who drinks large amounts of alcohol may become aggressive or violent, suffer nausea and vomiting, and show poor judgement such that they do things they would not normally do. Excessive alcohol consumption is associated with a great deal of violence, including violence in the home against one's spouse or children.

Another example of **harmful drug use** may be a person who takes a large amount of methamphetamine on weekends, and spends several days recovering from its effects.

It is important to note that although a person can experience harmful drug use, it does not mean they are drug dependent. There are specific criteria that determine if a person is drug dependent, discussed below.

Drug dependence

Drug dependence is a chronic medical condition characterised by the following symptoms:

Tolerance: the need to consume increasing amounts of a drug to obtain the desired effect

Withdrawal: physical and psychological symptoms that the person experiences when they reduce or stop using a drug. Withdrawal symptoms are relieved by resuming use of the drug.

Lack of control: the person finds it extremely difficult to control their use of the drug. For example, they may use more of the drug than intended, or may use it over a longer period of time than intended. The person may want to stop or reduce their drug use, but is unsuccessful in attempts to do so.

Narrowing of behaviour: the person's life comes to revolve around drug seeking and drug use. Other activities, such as work, parenting or seeing friends, are not as important as obtaining and using drugs.

Continued use despite problems: the person continues to use the drug, even though they know it is causing problems and that they may be punished for their drug use.

A person needs to display all or most of these symptoms before he or she can be considered drug dependent. Note that **drug dependence cannot be determined from the amount or frequency of drug use alone.**
You cannot become dependent on a drug after using it once. Drug dependence only develops

following frequent (e.g. daily or almost daily) use of a drug over a period of weeks or months. People who are drug dependent are not bad or weak; they have a medical condition that requires ongoing treatment.

Drug dependence causes changes in the way the brain's **neurotransmitter** systems work. A full explanation of the neurological processes underlying drug dependence is beyond the scope of these guidelines. However, interested readers are referred to the World Health Organization booklet *Neuroscience of Psychoactive Substance Use and Dependence*, available in many languages from http://www.who.int/substance_abuse/publications/psychoactives/en/index.html.

Treating drug dependence

Drug dependence is a chronic condition. There are no easy 'cures' for drug dependence. Rather, treatment is ongoing and relapse is common. It is helpful to think of drug dependence as similar to other chronic diseases, such as diabetes. A person with diabetes is not 'cured' by treatment; rather, their illness is managed by daily medication. Similarly, a person who is drug dependent is not cured by treatment. Drug dependence is managed through a combination of medical and psychosocial therapies over many months or even years.

It is unrealistic to expect all drug dependent patients to stop using all drugs. Rather, understand that some patients will relapse to regular drug use, while others will be abstinent most of the time, but occasionally use drugs. Others will need to remain on substitution medications for many years.

These guidelines use a **stepped care approach** to treating drug dependence. This approach acknowledges that different people require different interventions around their drug use. For example, a person who is only an occasional user of methamphetamine needs much less intensive intervention than a person who is methamphetamine dependent.

1.2 DRUG USE AND HIV

Human immunodeficiency virus (HIV) is a virus that causes a person's immune system to weaken. This makes it difficult for the body to recover from illness. HIV is transmitted (passed from an infected person to a non-infected person) when the blood, semen or vaginal fluid of an infected person enters the bloodstream of a non-infected person.

HIV **cannot** be transmitted through casual contact, such as shaking hands with or sharing food with an infected person; sharing a toilet or shower with an infected person; mosquito bites; kissing; spitting; or sneezing and coughing.

There are ways to prevent HIV transmission. For example:

- Always using condoms during sex
- Always using sterile needles and syringes for injections
- HIV-infected women who become pregnant can take medication to reduce the risk of the virus being passed on to their children

Injecting drug use is one of the key drivers of the HIV epidemic in many countries in the Asian

region. The virus is transmitted when people who inject drugs (PWID) share needles and syringes that are contaminated with HIV-infected blood. It can then be passed on to other people through sex or drug injection. Hence, anyone can become infected with HIV.

HIV in closed settings

HIV prevalence in closed settings is higher than in the wider community, due in part to the high level of injecting drug use among people detained in closed settings.

HIV risk behaviours do not stop once a person enters a closed setting. Although activities like sex, drug use and tattooing are illegal in prisons, they still occur. When people inject drugs in closed setting, they usually share injecting equipment with many others, including people who may have HIV or other infectious diseases. The same applies to tattooing needles, which are usually used on many detainees.

Sex in closed settings may be between detainees, including detainees of the same sex. It may also be between detainees and staff. Sex in closed settings may be consensual or coerced. Sex in closed settings is usually unprotected and carries the risk of HIV or other sexually transmitted infections.

HIV does not stay inside the walls of the closed setting. When a detainee is released, he or she may unknowingly transmit HIV to their injecting or sexual partners in the community. Hence, HIV prevention in closed settings is necessary to protect the whole community.

WHO and UNODC guidance on HIV prevention in closed settings is available. See:

Inside Out: HIV Harm Reduction Education for Closed Settings and
HIV/AIDS Treatment and Care for Injecting Drug Users in Asia: A Guide to Essential Practice, both available from
http://www.wpro.who.int/health_topics/harm_reduction/

HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings, available from
http://data.unaids.org/pub/Report/2006/20060701_hiv-aids_prisons_en.pdf

HIV and AIDS in Places of Detention, available from
http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

PART TWO

Professional and ethical practice in closed settings

2.1 RESPECT FOR HUMAN RIGHTS

The human rights standards that apply in closed settings have been clearly articulated in:

- The Universal Declaration of Human Rights
- The United Nations Standard Minimum Rules for the Treatment of Prisoners
- The United Nations Basic Principles for the Protection of Prisoners

and many other international legal agreements. It is the responsibility of those managing closed settings to ensure that these rights are respected. Some of the most important points of these documents are summarised below.

Right to essentials of life

People who are detained in closed settings are entitled to receive

- Adequate, nutritious food
- Clean water
- Adequate shelter and floor space per person
- Hygienic facilities for bathing and toileting

Right to health

All people, including those in closed settings, have a right to health. This means that people in closed settings should be able to access healthcare of the same standard as that available in the surrounding community. All closed settings should employ medically-trained personnel who are available to all detainees for medical treatment as necessary.

The right to health includes the right to prevention of disease. This means that detainees in closed settings should have access to condoms and sterile needles and syringes to help prevent the spread of HIV, sexually transmitted infections and blood borne viral infections.

Right to freedom from torture, cruelty, inhuman or degrading punishment

Detainees should only be restrained (e.g. using handcuffs or chains) if:

- Restraints are necessary to prevent escape
- The detainee is a danger to him or herself or others

Restraints should never be used as punishment.

Humiliation of detainees by staff should never be permitted. Examples of humiliation may include discussing a detainee's drug use or other aspects of a detainee's life in front of other detainees or denigrating a detainee on the basis of gender, race or religion.

There is no justification for intentionally inflicting pain or suffering, whether physical or mental, on any detainee. Inflicting torture or cruelty on detainees can result in long-term physical and psychological illness.

Right to confidentiality

All people are entitled to have their health information kept confidential. It is not necessary

for security staff of closed settings to know the medical and psychological illnesses of a detainee.

2.2 EVIDENCE-BASED TREATMENT

People in closed settings should be provided with treatment and care that is based on scientific evidence. The treatment methods described in these guidelines are based on evidence.

There is **no evidence** that moral education, physical exercise or labour treats or assists in treating drug dependence.

If a closed setting is using a treatment method for which there is no or little scientific evidence, but that it believes to be effective, they have a responsibility to conduct research on that treatment and to submit their research findings to review by the scientific community.

2.3 HIV IN CLOSED SETTINGS

HIV testing

Compulsory HIV testing was common in closed settings during the early stages of the HIV epidemic. However, most jurisdictions have now abandoned the practice, recognising it as a counter-productive and expensive exercise that contravenes detainees' rights and produces little or no public health or security benefit. HIV testing should be made available to detainees, but it must be voluntary and accompanied by pre-test and post-test counselling.

Segregation

There is no security reason for segregating HIV-positive detainees from other detainees in the closed setting. Medically, the only time when it may be necessary to segregate a HIV-positive detainee is if the detainee is suffering a communicable disease such as infectious tuberculosis, or if the detainee is so immunosuppressed that his or her health would be at risk from exposure to the general prison population.

Even if all detainees are tested for HIV, it is not possible to identify all those who are HIV-positive. A HIV test looks for antibodies to the virus; it can take three months from infection for enough antibodies to be produced to be detected by the test. Hence, a person may be HIV-positive but return a negative test result. Therefore, segregating detainees by HIV status creates a false sense of security – people believe that they are in an 'HIV-free' environment, but this is not necessarily the case.

Even if it were possible to correctly identify HIV-positive detainees every time, this is still no reason to segregate detainees. A more appropriate measure is known as 'universal precautions'. This approach assumes that everyone – including healthcare workers and security guards – are potential carriers of HIV or other infections, and therefore you should avoid coming into contact with any person's blood or other bodily fluids. This is achieved by using gloves, surgical masks and other protective equipment whenever there is potential for contact with bodily fluids. It is NOT necessary to use gloves or face masks when simply assessing or talking to a detainee.

Confidentiality of HIV status

There is no medical or security reason for a detainee's HIV status to be widely known. Medical staff that are aware of a detainee's HIV-positive status are required to treat this information as confidential.

2.4 SPECIAL POPULATIONS IN CLOSED SETTINGS

The majority of people detained in closed settings are men. However, there are women, juveniles and transgender[1] people in closed settings. All of these groups are particularly vulnerable to sexual and physical abuse in closed settings and require special consideration.

Women in closed settings

Women in closed settings often have very poor health. HIV prevalence is often higher among women in closed settings than among men in closed settings. Furthermore, women in closed settings are vulnerable to sexual abuse by closed setting staff and male detainees.

Women in closed settings should be housed separately from men and from juvenile prisoners; this may mean separate institutions for women, or a separate unit for women within a larger institution.

Women in closed settings should be able to access healthcare that is appropriate to their needs, particularly in relation to reproductive and sexual health. This includes access to condoms, dental dams and lubricants. It may be illegal for staff and detainees to have sex, but it does happen and women must be able to access tools to prevent HIV and sexually transmitted infections.

Women also require access to basic items for menstrual health (e.g. tampons or sanitary cloths).

Transgender people in closed settings

A transgender person is someone whose psychological gender is different to his or her biological sex. For example, a person who is biologically male may consider himself to be female, and so dress and behave in a female manner (or vice versa). Transgender people are vulnerable to physical and sexual abuse in closed settings.

For safety reasons, both male-to-female transgender detainees and female-to-male transgender detainees should be housed with female detainees. Transgender detainees should be referred to using their preferred name and gender pronoun. For example, a transgender person who is biologically male but female in appearance should be referred to as 'she' and using her female name.

Transgender detainees are entitled to confidentiality around their transgender status. They should not be required to disclose or discuss their transgender status with any staff or detainees.

Juveniles in closed settings

The definition of a juvenile varies between countries, but the term juvenile is usually used to refer to offenders under the age of 18 years. Juveniles in closed settings are vulnerable to sexual and physical abuse from older detainees and staff of the closed setting. Juveniles should not be housed in the same accommodation as adult male or female detainees. Male and female juveniles should be housed separately from each other.

Before detaining a juvenile, consider whether detention is the best option; detention is highly stigmatising and may negatively affect the rest of the young person's life. It is usually preferable that the juvenile be rehabilitated in a community setting. Children should not be detained in closed settings at all, but referred to more appropriate services, such as NGOs specialising in care and support of children.

PART THREE

Assessment and treatment planning using the stepped care approach

3.1 CONDUCTING AN ASSESSMENT

Assessment is the process of obtaining information about the patient's drug use and how it is affecting his or her life. It is an essential part of treatment and care for people who use drugs.

The person conducting the assessment should be a healthcare worker – a doctor, nurse, psychologist or other person with a health-related qualification.

It is important that the information obtained in the assessment is honest and accurate. But, talking about drug use can be difficult. Patients may be reluctant to talk about their drug use. They may be embarrassed, or they may fear punishment if they disclose drug use. The patient may be under the influence of drugs **(intoxicated)** on their admission to the closed setting, in which case they may not be able to answer the assessment questions accurately. Hence, before commencing the assessment, it is important to do three things:

1. **Is the patient able to complete the assessment?** If the patient is under the influence of drugs, including alcohol, it may be better to wait a few hours before assessing the patient. If the patient is in withdrawal and not able to answer questions, they should be provided with symptomatic treatment as required and allowed to stabilise before the assessment is completed.

2. **Establish rapport** with the patient. If you just start asking questions, the patient is unlikely to answer honestly. Instead, spend a few minutes on 'small talk'. Introduce yourself, and ask the patient for his or her name. Ask an open-ended, non-threatening question, such as "How are you feeling today?", and pay attention to the patient's response. The aim is to show the patient that you are genuinely interested in, and have empathy for, his or her situation.

3. **Explain the assessment process** to the patient. During an assessment, the patient may be asked to reveal very personal and private information. It is important that you explain why you are asking these questions, and what you will do with the information that the patient gives you. For example, "I'm going to ask you some questions about your drug use. We need to know this information so that we know what withdrawal symptoms to prepare you for, and also so that we can plan your treatment". Reassure the patient that the assessment is confidential. Before you begin the assessment, ask the patient if he or she has any questions for you.

3.2 AREAS OF ASSESSMENT

Note that all the questions and scales referred to in this section are collected in a standardised assessment form starting on page 21.

Drug use history

Find out about all drugs the patients has used and how he or she has used them. A **drug use history form** is included in the standardised assessment form for this purpose (p.22). This form lists different drug types and for each drug asks:

- How old were you when you first used this drug?

- How long have you used this drug regularly?
- Frequency of use and amount used over the past 3 months
- Last episode of drug use
- Route of administration
- Have you ever overdosed?
- Have you ever experienced withdrawal symptoms in the past?

Ask the patient these questions for each drug type listed. In addition, if the patient responds that they have injected a drug, ask about injecting behaviours (p. 23):

- Have you ever used a needle or syringe after some one else has used it?
- Do you have any infections or sores around where you inject?
- Have you been tested for HIV, hepatitis C or hepatitis B?

Provide all patients who inject drugs with information about HIV transmission and prevention.

If the patient indicates they have previously experienced withdrawal symptoms, ask:

- What symptoms did you experience?
- What did you do or what medications did you take to relieve these symptoms?
- Did you experience any serious complications such as seizures or hallucinations?
- Do you have any concerns about your withdrawal?
- Do you feel that you are in withdrawal now?

If the patient has concerns or is in withdrawal, do your best to alleviate this. Provide accurate information about what symptoms can be expected and how long they may last. If possible, provide medication to relieve symptoms.

Ask the patient if he or she has previously undergone treatment for their drug use. Find out what sort of treatment, and whether they found it helpful.

Assess whether the patient is **drug dependent**. This can be done using the **Severity of Dependence Scale** (SDS; p. 24). Ask the patient the SDS questions for the main drug or drugs the patient uses. If the patient equals or exceeds the shown cut-off score for a particular drug, it is likely that they are dependent on that drug. Note that the SDS is not used to assess dependence on inhalants. There are no reliable instruments for assessing inhalant dependence; rely on patient reports of previous withdrawals to guide decision-making around inhalant dependence.

Psychosocial history

It is also important to obtain an understanding of how the person's drug use has affected their daily life. You might say to the patient "thank you for co-operating with the assessment so far. Now, I'd like to ask you a little bit about how drugs have affected your life. Can you tell me about your family?"

When asking questions about a patient's family and friends, be sure that the patient understands that you are not asking the patient to tell you the names of other people who use drugs – you just want to understand how drug use has affected their life.

Ask the patient to describe their:

- Family situation – do family members know about your drug use? Are they willing to be a supportive influence?
- Other close relationships – do you have a girlfriend or boyfriend (remember that some patients may have same-sex partners)? Are you married? Has drug use affected your relationship with this person? Does he/she use drugs? Do you have children? Who is caring for your children? How many close friends do you have? Do many of your friends use drugs?
- Employment situation – were you employed before you came to the closed setting? What sort of work have you done in the past? Do you want employment training to help you get a job after you leave the closed setting?

Medical history

REMINDER: DUTY OF CLOSED SETTINGS TO PROVIDE CARE
Closed settings have a duty to provide health care equivalent to that available in the community. Hence, if a patient discloses that they have a serious or chronic illness, it is the responsibility of the closed setting to provide treatment or care for that illness, including medication as appropriate.

A drug dependent patient's withdrawal can be complicated by medical illnesses. However, the patient may not understand why you want to know about their medical history. Introduce the medical history questions with a phrase such as "now, I'd like to ask you about any medical problems you may have had in the past, or have now. This is very important, as it will help us if you suddenly get sick or if you need medication."

Ask the patient if they have any history of, or currently have:

- Seizures or epilepsy
- Diabetes
- Heart disease
- Liver disease
- Viral hepatitis
- Tuberculosis
- Head injury
- Physical or intellectual disability (note type of disability)
- Allergies to any medications
- Any prescribed or over-the-counter medications they are currently taking

Female patients should be asked if they are pregnant and offered the opportunity to take a pregnancy test.

Many people who use drugs have poor mental health. Ask the patient:

- Have you ever been diagnosed with schizophrenia?
- Have you ever been diagnosed with depression or bipolar disorder?
- Have you ever been diagnosed with post-traumatic stress disorder?
- Have you ever been diagnosed with any other mental health problem?

- Have you ever been given medication for a mental illness?
- Have you ever deliberately hurt yourself or tried to kill yourself? Do you feel like you may try to hurt or kill yourself?

Patients who have been taking medications for mental health problems should be permitted to continue these.[2] Patients who disclose self-harming or suicidal intent should be referred to a psychiatrist or psychiatric nurse for further assessment and care. They may need to be taken from the closed setting and hospitalised.

Administer the **Kessler-10 Psychological Distress Scale** (K10; p. 27). This scale provides an indication of levels of psychological distress experienced by the patient. Patients who have been diagnosed with a mental illness, or who are experiencing moderate or severe psychological distress according to the K10, should be provided with specialised psychiatric or psychological care.

Ending the assessment

Completing an assessment can be a difficult thing for some patients. It may be the first time they have spoken to anyone about their drug use or other problems. At the end of the assessment, explain to the patient that you will now take some time to go through what you have written down, and will develop a treatment plan that you think is suitable for the patient.

If the patient is distressed, provide reassurance and ensure the patient is regularly supervised. In cases of severe distress, refer to specialist psychiatric or psychological care.

Standardised assessment form

Patient name	
Date of birth	
Patient record number	
Date of admission	
Assessment conducted by	
Date of assessment	

[2] An exception to this may be patients who began taking benzodiazepines for an anxiety disorder, but have developed dependence. It may be necessary to withdraw these patients from benzodiazepines.

DRUG USE HISTORY

Drug: (For each category list the specific name or type of drug used)	How old were you when you first used this drug?	How long have you used this drug regularly?	Drug use in the last 3 months:		Last time drug was used:		Route of administration				**Have you ever overdosed?**	**Have you experienced withdrawal symptoms in the past?**
			Frequency of use	Amount used each occasion	Time since last use	Amount last used	*By mouth*	*Smoked*	*Injected*	Other		
Alcohol												
Heroin												
Other opioids												
Benzodiazepines												
Methamphetamine/ amphetamine												
Cannabis												
Ecstasy												
Inhalants												
Other												
								If YES ask risk behaviour questions				If YES ask risk behaviour questions

Injecting behaviours

	Yes/no	If yes,
Do you have any sores or infections around your injecting sites?		Arrange for medical examination and treatment
Have you injected drugs using a needle that had already been used by someone else?		Provide information about HIV transmission
Have you ever been tested for HIV or hepatitis C?		Can you tell me the results?[3]
Record test results, if provided:		

Withdrawal symptoms and previous treatments

What withdrawal symptoms did you experience?	
What did you do, or what medications did you take, to relieve these symptoms? Did they work?	
Did you experience any serious complications such as seizures or hallucinations?	
Do you have any concerns about your withdrawal? (If yes, provide information about withdrawal and how it will be managed)	
Do you feel you are in withdrawal now? (If yes, find out what symptoms and offer symptpomatic medication)	
What treatments for drug dependence have you previously undertaken? Were they helpful?	

[3] Although you may ask patients if they have been tested for HIV, you cannot force them to tell you their test result; it is up to the patient to decide whether to reveal this information

Severity of Dependence Scale

The following questions are about your drug use before coming to this centre.

In the last month, what was your primary drug, or the drug that you used the most often?

(When reading out the text below, replace "drug" with the type of drug the patient has nominated as his or her primary drug)

For each of the next five questions, please indicate the most appropriate response as it applied to your use of "drug".

	Never/almost never	Sometimes	Often	Always/nearly always
1. Did you think your use of "drug" was out of control?	0	1	2	3
2. Did the prospect of not using "drug" make you anxious or worried?	0	1	2	3
3. Did you worry about your use of "drug"?	0	1	2	3
4. Did you wish you could stop using "drug"?	0	1	2	3
	Not difficult	**Quite difficult**	**Very difficult**	**Impossible**
5. How difficult did you find it to stop or go without "drug"?	0	1	2	3

Add the scores for questions 1-5 to obtain the total SDS score for this drug:

Drug	SDS score indicating dependence
Alcohol	3 or more
Cannabis	7 or more
Heroin, other opioids	5 or more
Methamphetamine, amphetamine	4 or more
Cocaine	3 or more
Benzodiazepines	6 or more

Compare the total SDS score to the table below to assess dependence on this drug.

Psychosocial history

Can you tell me about your family? (Who are the members of your family? What is your relationship with them like? Does your family know about your drug use? Are they willing to support you after you are released?)	
Can you tell me about any other significant relationships in your life?[4] (Do you have a girlfriend/ boyfriend/wife/husband? How has drug use affected your relationship? Does he/she use drugs? Do you have children? Who is caring for them? How many close friends do you have? Do they use drugs? How has drug use affected your relationships with your friends?)	
Can you tell me about what work or study you did before you came here? (Were you employed? What skills do you have? Do you want employment training to help you get a job after you are released?)	

[4] Emphasise to the patient that you are asking these questions to find out about how drug use has affected his or her life and relationships – you are not asking the patient to give you names of other drug users.

Medical history

PHYSICAL HEALTH		
Do you have any history of…		**Details**
Seizures or epilepsy?	☐	
Diabetes?	☐	
Heart disease?	☐	
Liver disease?	☐	
Viral hepatitis?	☐	
Tuberculosis?	☐	
Head injury?	☐	
Physical or intellectual disability?	☐	
Allergies to any medication?	☐	
What medications are you currently taking?		
For female patients: Is there any possibility you may be pregnant?		

MENTAL HEALTH		
Have you ever been diagnosed with…		**Details**
Schizophrenia?	☐	
Depression or bipolar disorder?	☐	
Post-traumatic stress disorder?	☐	
Other mental health problems?	☐	
Have you ever deliberately hurt yourself or tried to kill yourself?	☐	
Do you feel like you may hurt yourself or want to kill yourself at the moment?	☐	

Kessler-10 Psychological Distress Scale (K-10)

These questions are about how you have been feeling in the **past 4 weeks**. Please listen to each question and tell me how much it has applied to you over the past 4 weeks – none of the time, a little of the time, some of the time, most of the time, or all of the time.

(Read out response options after each question)

In the past 4 weeks,	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. How often did you feel worn out for no good reason?	1	2	3	4	5
2. How often did you feel nervous?	1	2	3	4	5
3. How often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. How often did you feel hopeless?	1	2	3	4	5
5. How often did you feel restless or fidgety?	1	2	3	4	5
6. How often did you feel so restless you could not sit still?	1	2	3	4	5
7. How often did you feel depressed?	1	2	3	4	5
8. How often did you feel that everything was an effort?	1	2	3	4	5
9. How often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. How often did you feel worthless?	1	2	3	4	5

Add the scores for questions 1-10 to obtain the total K10 score:

Compare the total score to the table below to determine level of psychological distress:

Score	Interpretation
10-19	No/low psychological distress
20-24	Mild psychological distress
25-29	Moderate psychological distress
30-50	Severe psychological distress

3.3 TREATMENT PLANNING USING THE STEPPED CARE APPROACH

Different people have different withdrawal management and treatment needs. Each patient in a closed setting should have a **treatment plan**: a document that sets out what treatment he or she will be offered while in the closed setting.

Developing a treatment plan involves reviewing the patient's assessment and consulting with the patient as necessary. The patient has the right to be involved in making decisions about what treatment he or she receives, and involving the patient can help to improve patient co-operation with treatment.

The treatment plan should be developed using the **stepped care approach.** Stepped care involves matching treatment to patients based on the **least intensive intervention that is expected to be effective**. Based on how the patient responds to the chosen intervention, the healthcare worker can increase ('step up') or reduce ('step down') the intensity of treatment. This approach optimises the use of resources by reducing unnecessarily intensive treatment.

Developing a treatment plan

A template for developing a treatment plan is provided on page 31. To develop a treatment plan, use the patient's assessment to answer the following questions:

Does the patient require withdrawal management?

Patients will only need withdrawal management if they are dependent on a drug. To determine if this is the case, check whether the patient's Severity of Dependence Scale score indicates dependence. Also check whether the patient reported previously or currently experiencing withdrawal symptoms. These are all signs that a patient may require withdrawal management.

If the patient is dependent on heroin or other opioids, discuss the option of methadone maintenance treatment (MMT) or other opioid substitution treatment (OST). Patients commencing MMT do not need to undergo withdrawal before starting treatment.

Patients who are not dependent on any drug will not need withdrawal management and can commence treatment immediately.

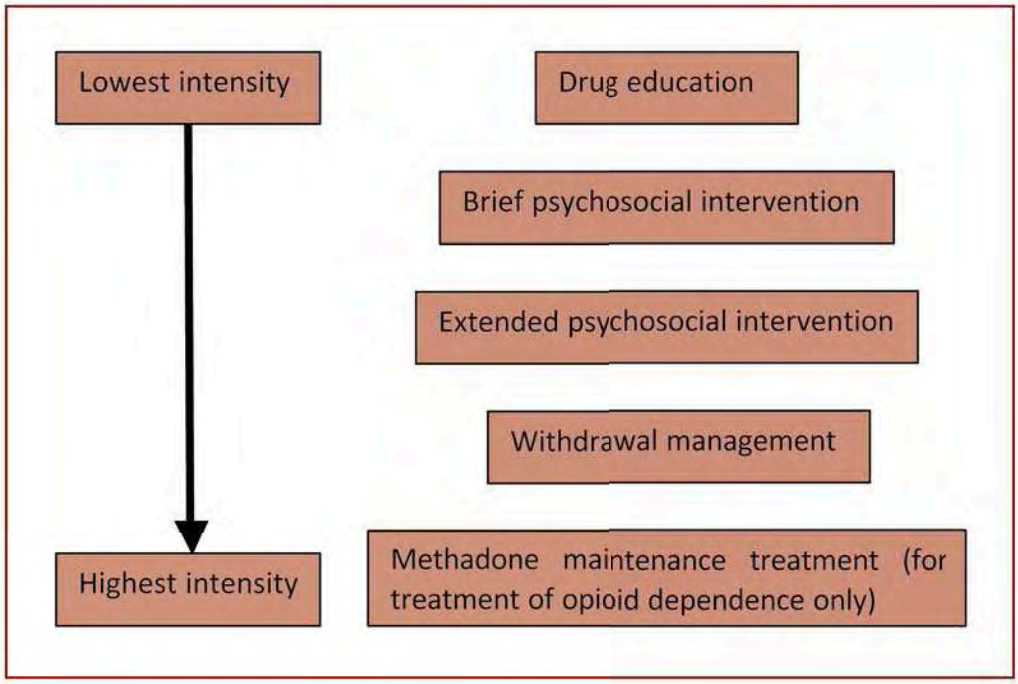
If withdrawal management is required, what drug/s is/are the patient withdrawing from?

Select the appropriate withdrawal management protocol from Part 4: Withdrawal Management. If a patient is withdrawing from a drug not discussed in these guidelines, seek assistance from colleagues or access other resources to guide withdrawal management.

What is the least intensive treatment that I expect to be effective for this patient?

Based on the patient's reported drug use, determine the least intensive treatment that you consider will have an impact on the patient. The interventions that are discussed in these guidelines are ranked by their intensity in Figure 1.

Figure 1: Intensity of interventions for stepped care treatment planning



Remember that not all people who use drugs need lengthy treatment; for some people, a brief education session may be all that is required. For others, a two-step treatment plan may be devised, with the patient completing withdrawal management and then stepping down in intensity to psychosocial interventions. See Table 1 for some examples of appropriate treatment approaches for different patients.

Table 1: Examples of stepped care treatment approaches

Presenting problem	*Appropriate treatment approach*
Patient uses methamphetamine occasionally, but is not experiencing any drug-related harm and is not dependent	Drug education (from the brief psychosocial intervention)
Patient is experiencing harms associated with methamphetamine use, but is not dependent	Brief psychosocial intervention
Patient is methamphetamine dependent	Step 1: Stimulant withdrawal management Step 2: Extended psychosocial intervention
Patient is heroin dependent	Commence methadone maintenance treatment OR Step 1: Opioid withdrawal management Step 2: Extended psychosocial intervention

What other patient concerns need to be addressed?

Patients may have other medical and psychological concerns that require attention, such as medication for other illnesses. Ensure that these needs are met.

Inform the patient about other opportunities in the closed setting, such as vocational training or performance groups. These activities complement the treatments described in these guidelines.

If the closed setting has the capacity to provide HIV tests, including pre- and post-test counselling, offer the patients the opportunity to take an HIV test. Testing should only be conducted voluntarily after informed consent has been obtained from the patient.

Treatment plan review: Stepping up or stepping down

Once a treatment plan has been commenced, it is important to regularly evaluate the patient's progress and determine if the interventions that were used have been useful to the patient. This provides a basis for either 'stepping up' - increasing the intensity of the intervention - or 'stepping down' - decreasing the intensity of the intervention.

If the patient has progressed well in treatment, then the intensity of treatment is reduced. Methods for reducing the intensity of treatment may include:

- Reducing the frequency of treatment sessions.
- Altering the way the session is delivered e.g. providing patients with self-help material instead of a face-to-face session.
- Ending treatment.

If the patient is not progressing in treatment, then the intensity of treatment may need to be increased. Methods for increasing the intensity of treatment may include:

- Increasing the frequency of treatment sessions.
- Introducing new treatment sessions e.g. moving from the brief intervention to the extended intervention.
- Introducing new issues into treatment sessions e.g. discussing mental health as well as drug use.

It is important to note that if a person is being successfully treated with methadone maintenance treatment, they should remain on this treatment and be assisted to transfer to community-based methadone treatment when they leave the closed setting.

Treatment plan template

1. Does the patient require withdrawal management?

Yes	☐	**No**	☐
Justification:	☐ Drug dependent	Justification:	☐ Not drug dependent
	☐ Previous withdrawal symptoms		☐ Opioid dependent and commencing methadone maintenance treatment
	☐ Current withdrawal symptoms		☐ Other:
	☐ Other:		

2. Withdrawal management plan selected:

- ☐ Opioid withdrawal management
- ☐ Benzodiazepine withdrawal management
- ☐ Stimulant withdrawal management
- ☐ Alcohol withdrawal management
- ☐ Inhalant withdrawal management
- ☐ Cannabis withdrawal management
- ☐ Other:
- ☐ Not applicable; patient does not require withdrawal management

3. Treatment/s selected:

- ☐ Drug education
- ☐ Brief psychosocial intervention
- ☐ Extended psychosocial intervention
- ☐ Methadone maintenance treatment
- ☐ Other:

4. Other patient concerns and how they will be managed:

5. Date for treatment plan review:

PART FOUR

Withdrawal Management

4.1 INTRODUCTION

Withdrawal management (WM) refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.[5]

People who are not dependent on drugs will not experience withdrawal and hence do not need WM. Refer to the patient's assessment to determine if he or she is dependent and requires WM.

Patients who are opioid dependent and consent to commence methadone maintenance treatment do not require WM; they can be commenced on methadone immediately (see opioid withdrawal protocol for more information).

It is very common for people who complete withdrawal management to relapse to drug use. It is unrealistic to think that withdrawal management will lead to sustained abstinence. Rather, withdrawal management is an important first step before a patient commences psychosocial treatment.

Providing withdrawal management in a way that reduces the discomfort of patients and shows empathy for patients can help to build trust between patients and treatment staff of closed settings.

4.2 STANDARD CARE FOR WITHDRAWAL MANAGEMENT

Patients in withdrawal should be accommodated away from patients who have already completed withdrawal. Healthcare workers should be available 24 hours a day. Workers should include:

A doctor who sees patients on admission and is on call to attend to the patient in case of complications;

Nurses, who are responsible for monitoring patients in withdrawal, dispensing medications as directed by the doctor and providing the patient with information about withdrawal.

The WM area should be quiet and calm. Patients should be allowed to sleep or rest in bed if they wish, or to do moderate activities such as walking. Offer patients opportunities to engage in meditation or other calming practices.

Patients in withdrawal should **not** be forced to do physical exercise. There is no evidence that physical exercise is helpful for WM. Physical exercise may prolong withdrawal and make withdrawal symptoms worse.

Patients in withdrawal may be feeling anxious or scared. Offer accurate, realistic information about drugs and withdrawal symptoms to help alleviate anxiety and fears.

[5] The term 'withdrawal management' (WM) has been used rather than 'detoxification'. This is because the term detoxification has many meanings and does not translate easily to languages other than English.

Do not try to engage the patient in counselling or other psychological therapy at this stage. A person in withdrawal may be vulnerable and confused; this is not an appropriate time to commence counselling.

During withdrawal some patients may become disruptive and difficult to manage. There may be many reasons for this sort of behaviour. The patient may be scared of being in the closed setting, or may not understand why they are in the closed setting. The patient may be disoriented and confused about where they are. In the first instance, use **behaviour management strategies** to address difficult behaviour (Table 2).

Table 2: Strategies for managing difficult behaviour[6]

Behaviour	Management strategy
The patient is anxious, agitated or panicking	Approach the patient in a calm and confident manner Reduce the number of people attending to the patient Carefully explain any interventions and what is going on Minimise the risk of self harm
The patient is confused or disorientated	Ensure the patient is frequently supervised Provide reality orientation – explain to the patient where they are and what is going on
The patient is experiencing hallucinations	Talk to the patient about what they are experiencing and explain what is and isn't real Ensure the environment is simple, uncluttered and well lit Protect the patient from harming him or herself and others
The patient is angry or aggressive	Ensure that staff and other patients are protected and safe When interacting with the patient remain calm and reassuring Listen to the patient Use the patient's name to personalise the interaction Use calm open-ended questions Use a consistent and even tone of voice, even if the patient becomes hostile and is shouting Acknowledge the patient's feelings Do not challenge the patient Remove source of anger if possible

Withdrawal symptoms vary according to the drug of dependence and severity of dependence, but often include nausea, vomiting, diarrhoea, anxiety and insomnia. Table 3 provides guidance on medications for alleviating common withdrawal symptoms.

[6] Adapted from NSW Detoxification Clinical Practice Guidelines, Sydney, NSW Department of Health, 1999.

Table 3: Symptomatic medications in withdrawal management

Symptom	Medication	Dose	Route	Frequency	Contraindications
Insomnia	Temazepam	10-30 mg	By mouth	As required, before going to bed	Benzodiazepine withdrawal
	Promethazine	25-75 mg	By mouth	As required, before going to bed	Benzodiazepine withdrawal
Nausea +/-vomiting	Metoclopramide	10mg	By mouth or Intramuscular injection	Every 4-6 hours as required up to 3 times per day	Dystonic reactions
	Prochlorperazine	5mg	By mouth	Up to 3 times per day as required	Dystonic reactions
Abdominal cramps	Propantheline	15mg	By mouth	Up to 3 times per day as required	
	Hyoscine Butylbromide	20mg	By mouth	Up to 3-4 times per day as required for up to 2-3 days	Diarrhoea caused by bacterial infection
Diarrhoea	Kaolin mixture	15-20 ml	By mouth	4 times per day as required	
	Loperamide	4mg initially, then 2mg	By mouth	4mg initially then 2mg after each unformed stool up to a maximum of 16mg per day	
Muscle cramps	Quinine sulphate	300mg	By mouth	2 times per day as required	Allergy to quinine
Headaches and other pains	Paracetamol/ Codeine phosphate	1000mg/ 16mg	By mouth		
	Paracetamol/ Orhenadrine	900mg/ 35mg	By mouth	3 times per day	
	Paracetamol	1000mg	By mouth	4-6 hourly as required up to 4000mg per day	
	Ibuprofen	400mg	By mouth	3 times per day as required	Gastric ulcer Gastritis Asthma
	Celecoxib		By mouth		
Agitation, anxiety and restlessness	Diazepam	5mg	By mouth	2-3 times per day, reducing over 3-5 days	Benzodiazepine withdrawal

4.3 WITHDRAWAL MANAGEMENT FOR OPIOID DEPENDENCE

Opioids are drugs such as heroin, opium, morphine, codeine and methadone. Opioid withdrawal can be very uncomfortable and difficult for the patient. It can feel like a very bad flu. However, opioid withdrawal is not usually life-threatening.

There are some patients who should NOT complete opioid withdrawal:

Pregnant women: It is recommended that pregnant women who are opioid dependent do **not** undergo opioid withdrawal as this can cause miscarriage or premature delivery. The recommended treatment approach for pregnant, opioid dependent women is methadone maintenance treatment.

Patients commencing methadone maintenance treatment do not need to undergo withdrawal before commencing treatment.

Opioid withdrawal syndrome

Short-acting opioids (e.g. heroin): Onset of opioid withdrawal symptoms 8-24 hours after last use; duration 4-10 days.
Long-acting opioids (e.g. methadone): Onset of opioid withdrawal symptoms 12-48 hours after last use; duration 10-20 days.

Symptoms include:

- Nausea and vomiting
- Anxiety
- Insomnia
- Hot and cold flushes
- Perspiration
- Muscle cramps
- Watery discharge from eyes and nose
- Diarrhoea

Observation and monitoring

Patients should be monitored regularly (3-4 times daily) for symptoms and complications. The Short Opioid Withdrawal Scale (SOWS, p.37) is a useful tool for monitoring withdrawal. It should be administered 1-2 times daily. Use the SOWS score to select an appropriate management strategy.

Short Opioid Withdrawal Scale[7]

Symptom	Not present	Mild	Moderate	Severe
Feeling sick	0	1	2	3
Stomach cramps	0	1	2	3
Muscle spasms or twitching	0	1	2	3
Feeling cold	0	1	2	3
Heart pounding	0	1	2	3
Muscular tension	0	1	2	3
Aches and pains	0	1	2	3
Yawning	0	1	2	3
Runny/watery eyes	0	1	2	3
Difficulty sleeping	0	1	2	3

Add scores for total score:

Compare total score to table below to guide withdrawal management

Score	Suggested withdrawal management
0-10	Mild withdrawal; symptomatic medication only
10-20	Moderate withdrawal; symptomatic or opioid medication
20-30	Severe withdrawal; opioid medication

Management of mild opioid withdrawal

Patients should drink at least 2-3 litres of water per day during withdrawal to replace fluids lost through perspiration and diarrhoea. Also provide vitamin B and vitamin C supplements.

Symptomatic treatment (see Table 3) and supportive care are usually sufficient for management of mild opioid withdrawal.

Management of moderate to severe opioid withdrawal

As for management of mild withdrawal, but with the addition of clonidine or opioid medications such as buprenorphine, methadone or codeine phosphate:

Opioid withdrawal management using clonidine

Clonidine is an alpha-2 adrenergic agonist. It can provide relief to many of the physical symptoms of opioid withdrawal including sweating, diarrhoea, vomiting, abdominal cramps, chills, anxiety, insomnia, and tremor. It can also cause drowsiness, dizziness and low blood pressure.

Clonidine should be used in conjunction with symptomatic treatment as required. It should **not** be given at the same time as opioid substitution.

[7] Gossop, M. (1990). The development of a short opiate withdrawal scale. Addictive Behaviors, 15, 487-490

Measure the patient's blood pressure and heart rate before administering clonidine (Figure 2). Dose according to Table 4. Continue to monitor blood pressure and cease clonidine if blood pressure drops below 90/50mmHg.

Figure 2: Procedure for administering clonidine for moderate/severe opioid withdrawal

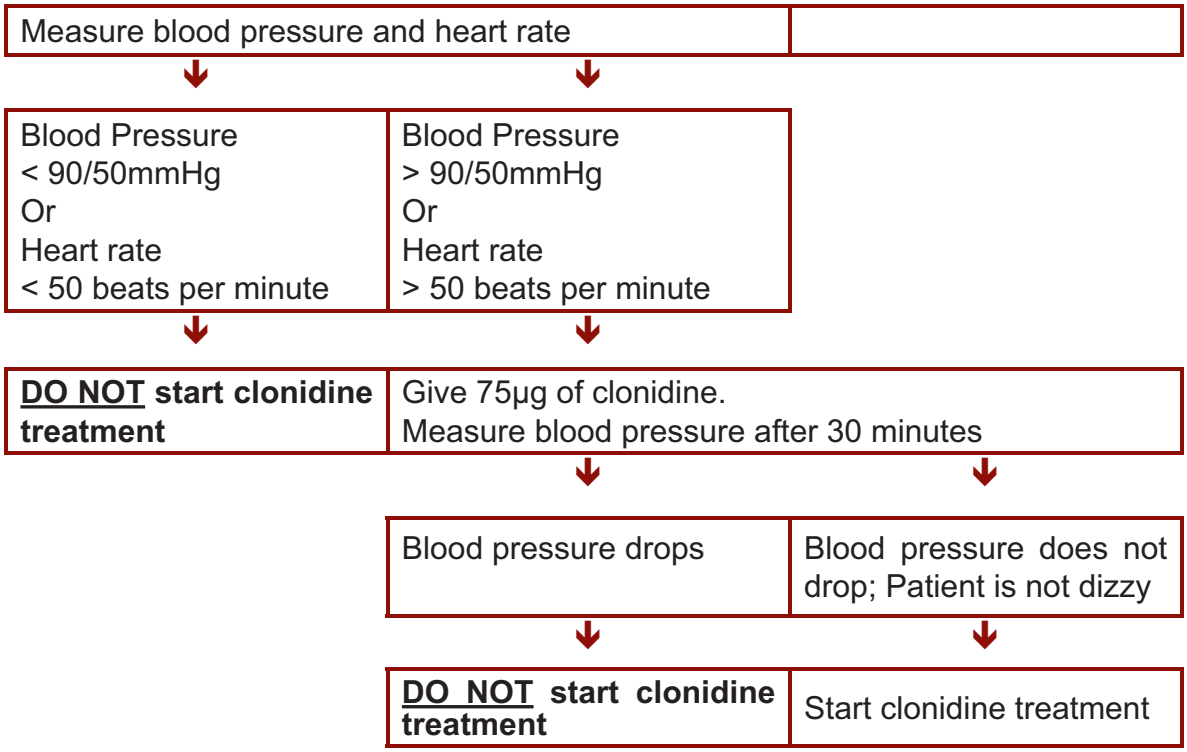


Table 4: Clonidine dosing for moderate/severe opioid withdrawal

	Morning	Early Afternoon	Night
Day 1	150 µg	150 µg	150 µg
Day 2	150-300 µg	150-300 µg	150-300 µg
Day 3	150-300 µg	150-300 µg	150-300 µg
Day 4	75 µg	75 µg	75 µg
Day 5	75 µg	Nil	75 µg

Opioid withdrawal management using buprenorphine

Buprenorphine is the best opioid medication for management of moderate to severe opioid withdrawal. It alleviates withdrawal symptoms and reduces cravings.

Because of its pharmacological action (partial opiate agonist), buprenorphine should only be given after the patient begins to experience withdrawal symptoms (i.e. at least eight hours after last taking heroin).

Buprenorphine should be used with caution in patients with:

- Respiratory deficiency
- Urethral obstruction
- Diabetes

The dose of buprenorphine given must be reviewed on daily basis and adjusted based upon how well the symptoms are controlled and the presence of side effects. The greater the amount of opioid used by the patient, the larger the dose of buprenorphine required to control symptoms. A suggested dosing protocol is shown in Table 5. Symptoms that are not satisfactorily reduced by buprenorphine can be managed with symptomatic treatment as required (see Table 3).

Table 5: Buprenorphine for opioid withdrawal management

	Recommended dose
Day 1	**6 mg**
Day 2	**8 mg**
Day 3	**10 mg**
Day 4	**8 mg**
Day 5	**4 mg**

Opioid withdrawal management using methadone

Methadone alleviates opioid withdrawal symptoms and reduces cravings. Methadone is useful for detoxification from longer acting opioids such as morphine or methadone itself.

Methadone should be used with caution if the patient has:

- Respiratory deficiency
- Acute alcohol dependence
- Head injury
- Treatment with monoamine oxidase inhibitors (MAOIs)
- Ulcerating colitis or Crohn's disease
- Severe hepatic impairment

The dose must be reviewed on daily basis and adjusted based upon how well the symptoms are controlled and the presence of side effects. The greater the amount of opioid used by the patient the greater the dose of methadone required to control withdrawal symptoms. A suggested dosing protocol is presented in Table 6. If symptoms are not sufficiently controlled either reduce the dose of methadone more slowly, or provide symptomatic treatment (see Table 3).

Table 6: Methadone for opioid withdrawal management

	Recommended dose
Days 1-4	**30 mg**
Days 5-8	**35 mg**
Day 9	**30 mg**
Day 10	**25 mg**
Day 11	**20 mg**
Day 12	**15 mg**
Day 13	**10 mg**
Day 14	**5 mg**
Day 15	0 mg

To avoid the risk of overdose in the first days of treatment methadone can be given in divided doses, for example, give 30mg in two doses of 15mg morning and evening.

Opioid withdrawal management using codeine phosphate

Codeine phosphate alleviates opioid withdrawal symptoms and reduces cravings. Codeine has no effect for 2–10% of people.

Codeine phosphate should be used with caution if the patient has:

- Respiratory deficiency
- Severe hepatic impairment

The dose must be reviewed on daily basis and adjusted based upon how well the symptoms are controlled and the presence of side effects. The greater the amount of opioid used by the patient the greater the dose of codeine phosphate required to control withdrawal symptoms. A suggesting dosing protocol is shown in Table 7. Symptoms that are not satisfactorily reduced by codeine phosphate can be managed with symptomatic treatment as required (see Table 3).

Table 7: Codeine phosphate for opioid withdrawal management

	Recommended dose
Days 1-3	240mg/day in 4 divided doses
Day 4	210mg/day in 4 divided doses
Day 5	180mg/day in 4 divided doses
Day 6	150mg/day in 4 divided doses
Day 7	120mg/day in 4 divided doses
Day 8	90mg/day in 3 divided doses
Day 9	60mg/day in 3 divided doses
Day 10	30mg/day in 2 divided doses

Follow-up care

Acute opioid withdrawal is followed by a protracted withdrawal phase that lasts for up to six months and is characterised by a general feeling of reduced well-being and strong cravings for opioids. This craving often leads to relapse to opioid use. To reduce the risk of relapse, patients should be engaged in psychosocial interventions such as described later in these guidelines. Patients who repeatedly relapse following withdrawal management are likely to benefit from methadone maintenance treatment or other opioid substitution treatment.

All opioid dependent patients who have withdrawn from opioids should be advised that they are at **increased risk of overdose** due to reduced opioid tolerance. Should they use opioids, they must use a smaller amount than usual to reduce the risk of overdose.

4.4 WITHDRAWAL MANAGEMENT FOR BENZODIAZEPINE DEPENDENCE

Benzodiazepines are central nervous system depressants. They are used to treat anxiety and sleeping disorders. When used appropriately, they are very effective in treating these disorders. However, when used for an extended period of time (e.g. several weeks), dependence can develop.

Benzodiazepine withdrawal syndrome

Benzodiazepines can have short or long durations of action. This affects the onset and course of withdrawal.

Short-acting benzodiazepines include oxazepam, alprazolam and temazepam. Withdrawal typically begins 1-2 days after the last dose, and continues for 2-4 weeks or longer.

Long-acting benzodiazepines include diazepam and nitrazepam. Withdrawal typically begins 2-7 days after the last dose, and continues for 2-8 weeks or longer

Symptoms include:

- Anxiety
- Insomnia
- Restlessness
- Agitation and irritability
- Poor concentration and memory
- Muscle tension and aches

These symptoms tend to be subjective, with few observable signs.

Observation and monitoring

Patients in benzodiazepine withdrawal should be monitored regularly for symptoms and complications.

The severity of benzodiazepine withdrawal symptoms can fluctuate markedly and withdrawal scales are not recommended for monitoring withdrawal. Rather, the healthcare worker should regularly (every 3-4 hours) speak with the patient and ask about physical and psychological symptoms. Provide reassurance and explanation of symptoms as necessary.

Management of benzodiazepine withdrawal

The safest way to manage benzodiazepine withdrawal is to give benzodiazepines in gradually decreasing amounts. This helps to relieve benzodiazepine withdrawal symptoms and prevent the development of seizures.

The first step in benzodiazepine withdrawal management is to stabilise the patient on an appropriate dose of diazepam. Calculate how much diazepam is equivalent to the dose of benzodiazepine that the patient currently uses, to a maximum of 40mg of diazepam (Table 8).

Table 8: Calculating diazepam equivalent doses

5 mg of *diazepam* is equivalent to:		
0.5mg	of *alprazolam*	**For example:** If the patient is using *4 mg of lorazepam* per day, this is equivalent to *40mg of diazepam* per day. If the patient is using *60 mg of temazepam* per day, this is equivalent to *30mg of diazepam* per day
3mg	of *bromazepam*	
10mg	of *clobazam*	
1mg	of *flunitrazepam*	
0.5mg	of *lorazepam*	
0.75mg	of *lormetazepam*	
5mg	of *nitrazepam*	
15mg	of *oxazepam*	
2.5mg	of *midazolam*	
10mg	of *temazepam*	
0.25mg	of *triazolam*	

This dose of diazepam (up to a maximum of 40mg) is then given to the patient daily in three divided doses. Even if the patient's equivalent diazepam dose exceeds 40mg, do not give greater than 40mg diazepam daily during this stabilisation phase.

Allow the patient to stabilise on this dose of diazepam for 4-7 days. Then, for patients taking less than the equivalent of 40mg of diazepam, follow the **low-dose benzodiazepine reducing schedule** (Table 9). For patients taking the equivalent of 40mg or more of diazepam, follow the **high-dose benzodiazepine reducing schedule** (Table 10).

Table 9: Low-dose benzodiazepine reducing schedule

Patients using less than 40mg/day diazepam equivalent				
	Time of dose			Total daily dose
	08:00	12:00	20:00	
Starting dose	5mg	5mg	5mg	15mg
1st reduction	5mg	2.5mg	5mg	12.5mg
2nd reduction	5mg	-	5mg	10mg
3rd reduction	2.5mg	-	5mg	7.5mg
4th reduction	-	-	5mg	5mg
5th reduction	-	-	2.5mg	2.5mg

Table 10: High-dose benzodiazepine reducing schedule

Patients using more than 50mg/day diazepam equivalent					
	Time of dose				Total daily dose
	08:00	12:00	17:00	21:00	
Starting dose	10mg	10mg	10mg	10mg	40mg
1st reduction	10mg	5 mg	5mg	10mg	30mg
2nd reduction	5mg	-	5mg	10mg	20mg
3rd reduction	-	-	-	10mg	10mg
4th reduction	-	-	-	5mg	5mg

The length of time between each dose reduction should be based on the presence and severity of withdrawal symptoms. The longer the interval between reductions, the more comfortable and safer the withdrawal. Generally, there should be at least one week between dose reductions.

Generally, benzodiazepine withdrawal symptoms fluctuate; the intensity of the symptoms does not decrease in a steady fashion as is the case with most other drug withdrawal syndromes. It is **not** recommended to increase the dose when symptoms worsen; instead, persist with the current dose until symptoms abate, then continue with the dose reduction schedule.

Symptomatic treatment can be used in cases where residual withdrawal symptoms persist (Table 3).

Follow-up care

Withdrawal management alone is unlikely to lead to sustained abstinence from benzodiazepines. The patient should commence psychosocial treatment as described in these guidelines.

Patients may have been taking benzodiazepines for an anxiety or other psychological disorder; following withdrawal from benzodiazepines, the patient is likely to experience a recurrence of these psychological symptoms. Patients should be offered psychological care to address these symptoms.

4.5 WITHDRAWAL MANAGEMENT FOR STIMULANT DEPENDENCE

Stimulants are drugs such as methamphetamine, amphetamine and cocaine. Although these drugs vary in their effects, they have similar withdrawal syndromes.

Stimulant withdrawal syndrome

Symptoms begin within 24 hours of last use of stimulants and last for 3-5 days.

Symptoms include:

- Agitation and irritability
- Depression
- Increased sleeping and appetite
- Muscle aches

People who use large amounts of stimulants, particularly methamphetamine, can develop psychotic symptoms such as paranoia, disordered thoughts and hallucinations. The patient may be distressed and agitated. They may be a risk of harming themselves or others. These symptoms can be managed using anti-psychotic medications and will usually resolve within a week of ceasing stimulant use.

Observation and monitoring

Patients withdrawing from stimulants should be monitored regularly. Because the mainstay of treatment for stimulant withdrawal is symptomatic medication and supportive care, no withdrawal scale has been included.

During withdrawal, the patient's mental state should be monitored to detect complications such as psychosis, depression and anxiety. Patients who exhibit severe psychiatric symptoms should be referred to a hospital for appropriate assessment and treatment.

Management of stimulant withdrawal

Patients should drink at least 2-3 litres of water per day during stimulant withdrawal. Multivitamin supplements containing B group vitamins and vitamin C are recommended. Symptomatic medications should be offered as required for aches, anxiety and other symptoms.

Management of severe agitation

A minority of patients withdrawing from stimulants may become significantly distressed or agitated, presenting a danger to themselves or others.
In the first instance, attempt **behavioural management strategies** as shown in Table 2 (page 33). If this does not adequately calm the patient, it may be necessary to sedate him or her using diazepam. Provide 10-20ng of diazepam every 30 minutes until the patient is adequately sedated. No more than 120mg of diazepam should be given in a 24-hour period. The patient should be observed during sedation and no more diazepam given if signs of respiratory depression are observed.

If agitation persists and the patient cannot be adequately sedated with oral diazepam, transfer the patient to a hospital setting for psychiatric care.

Follow-up care

Acute stimulant withdrawal is followed by a protracted withdrawal phase of 1-2 months duration, characterised by lethargy, anxiety, unstable emotions, erratic sleep patterns and strong cravings for stimulant drugs. These symptoms may complicate the patient's involvement in treatment and should be taken into account when planning treatment.

The preferred treatment for stimulant dependence is psychological therapy that focuses on providing patients with skills to reduce the risk of relapse (see Part 5: Psychosocial approaches to drug dependence treatment).

4.6 WITHDRAWAL MANAGEMENT FOR ALCOHOL DEPENDENCE

Alcohol withdrawal can be very difficult for the patient. In rare cases, alcohol withdrawal can be life-threatening and require emergency medical intervention. Hence, it is extremely important to assess patients for alcohol dependence and monitor alcohol dependent patients carefully.

Alcohol withdrawal syndrome

Alcohol withdrawal symptoms appear within 6-24 hours after stopping alcohol, are most severe after 36 – 72 hours and last for 2 – 10 days.

Symptoms include:

- Anxiety
- Excess perspiration
- Tremors, particularly in hands
- Dehydration
- Increased heart rate and blood pressure
- Insomnia
- Nausea and vomiting
- Diarrhoea

Severe withdrawal may involve complications:

- Seizures
- Hallucinations
- Delirium
- Extreme fluctuations in body temperature and blood pressure
- Extreme agitation

Observation and monitoring

Patients should be monitored 3-4 times daily for symptoms and complications. The Alcohol Withdrawal Scale (AWS, p.49) should be administered every four hours for at least three days, or longer if withdrawal symptoms persist. A patient's score on the AWS should be used

to select an appropriate management plan from below.

Alcohol Withdrawal Scale[8]

Date						
Time						
PERSPIRATION						
No abnormal sweating	0					
Moist skin	1					
Localised beads of sweat e.g. on face and chest	2					
Whole body wet from sweat	3					
Profuse maximum sweating – clothes, sheets are wet	4					
TREMOR						
No tremor	0					
Slight tremor upper extremities	1					
Constant light tremor upper extremities	2					
Constant marked tremor upper extremities	3					
ANXIETY						
No apprehension or anxiety	0					
Slight apprehension	1					
Apprehension or understandable fear	2					
Anxiety occasionally accentuated to state of panic	3					
Constant panic-like anxiety	4					
AGITATION						
Rests normally no sign of agitation	0					
Slight restlessness, cannot sit or lie still, awake when others sleep	1					
Moves constantly, looks tense, wants to get out of bed but obeys requests to stay into bed	2					
Constantly restless, gets out of bed for no obvious reason, returns to bed if taken	3					
Maximally restless, aggressive, ignores requests to stay in bed	4					
TEMPERATURE						
37.0°C or less	0					
37.1 – 37.5°C	1					
37.6 – 38.0°C	2					
38.1 – 38.5°C	3					
above 38.5°C	4					

[8] Nowak, H. (ed.) (1989). Nursing education and nursing management of alcohol and other drugs. Sydney: CEIDA.

HALLUCINATIONS						
No evidence of hallucinations	0					
Distortion of real objects, aware these are not real if this is pointed out	1					
Appearance of totally new objects or perceptions, aware that these are not real if this is pointed out	2					
Believes hallucinations are real but still orientated in place and person	3					
Believes himself to be in a totally non-existent environment, preoccupied and cannot be diverted or reassured	4					
ORIENTATION						
Fully orientated in time place and person	0					
Orientated in person but not sure where he is or what time it is	1					
Orientated in person but not time and place	2					
Doubtful personal orientation disoriented in time and place; there maybe short bursts of lucidity	3					
Disoriented in time, place and person, no meaningful contact can be obtained	4					
	Total score					

Compare score to table below for suggested management

AWS score	Suggested withdrawal management
1-4	Mild withdrawal: Symptomatic medications
5-14	Moderate withdrawal: Follow 'management of moderate alcohol withdrawal' protocol
15+	Severe withdrawal: Follow 'management of severe alcohol withdrawal' protocol

Management of mild alcohol withdrawal (AWS score 1-4)

Patients should drink 2-4 litres of water per day during withdrawal to replace fluids lost through perspiration and diarrhoea. Multivitamin supplements and particularly vitamin B1 (thiamine) supplements (at least 100mg daily during withdrawal) should also be provided to help prevent cognitive impairments[9] that can develop in alcohol dependent patients.

Provide symptomatic treatment (see Table 3) and supportive care as required.

Management of moderate alcohol withdrawal (AWS score 5-14)

As for management of mild alcohol withdrawal, with diazepam as in Table 11.

Table 11: Diazepam for management of moderate alcohol withdrawal

	Time of dose:			
	08:00	**12:00**	**17:00**	**21:00**
Days 1-2	10 mg	10 mg	10 mg	10 mg
Day 3	10 mg	5 mg	5 mg	10 mg
Day 4	5 mg	-	5 mg	10 mg
Day 5	-	-	-	10 mg

If the protocol in Table 11 does not adequately control alcohol withdrawal symptoms, provide additional diazepam (up to 120mg in 24 hours). Monitor the patient carefully for excessive sedation. Once symptoms are controlled, follow the protocol as above.

Management of severe alcohol withdrawal (AWS score 15+)

As for management of mild alcohol withdrawal, but patients in severe alcohol withdrawal also require diazepam sedation. This may involve very large amounts of diazepam, many times greater than would be prescribed for patients in moderate alcohol withdrawal.

Give 20mg diazepam by mouth every 1-2 hours until symptoms are controlled and AWS score is less than 5. Monitor the patient regularly during this time for excessive sedation.

In rare cases, alcohol dependent patients may experience severe complications such as seizures, hallucinations, dangerous fluctuations in body temperature and blood pressure, extreme agitation and extreme dehydration. These symptoms can be life-threatening. As above, provide 20mg diazepam every 1-2 hours until symptoms are controlled. Be aware that **very large** doses of diazepam may be needed for this. In cases of severe dehydration, provide intravenous fluids with potassium and magnesium salts.

Follow-up care

Withdrawal management rarely leads to sustained abstinence from alcohol. After withdrawal is completed, the patient should be engaged in psychosocial interventions such as described in Section 5.

Patients with cognitive impairments as a result of alcohol dependence should be provided with ongoing vitamin B1 (thiamine) supplements.

[9] Known as Wernicke's Encephalopathy.

4.7 WITHDRAWAL MANAGEMENT FOR INHALANT DEPENDENCE

Inhalant dependence and withdrawal is poorly understood. Some people who use inhalants regularly develop dependence, while others do not. Among heavy users, only some will experience withdrawal symptoms.

Inhalant withdrawal syndrome

Inhalant withdrawal symptoms can begin anywhere between a few hours to a few days after ceasing inhalant use. Symptoms may last for only 2-3 days, or may last for up to two weeks.

Symptoms include:

- Headaches
- Nausea
- Tremors
- Hallucinations
- Insomnia
- Lethargy
- Anxiety and depressed mood
- Irritability
- Poor concentration

Observation and monitoring

Patients withdrawing from inhalants should be observed every three-four hours to assess for complications such as hallucinations, which may require medication.

Management of inhalant withdrawal

Patients should drink 2-3 litres of water per day while in withdrawal. Provide a calm, quiet environment for the patient. Offer symptomatic medication as required for symptoms such as headaches, nausea and anxiety (Table 3).

Follow-up care

For up to a month after ceasing inhalant use, the patient may experience confusion and have difficulty concentrating. This should be taken into consideration in planning treatment involvement.

4.8 WITHDRAWAL MANAGEMENT FOR CANNABIS DEPENDENCE

Cannabis withdrawal syndrome

The cannabis withdrawal syndrome is typically mild, but can be difficult for the patient to cope with. Symptoms last between one and two weeks.

Symptoms include:

- Anxiety and a general feeling of fear and dissociation
- Restlessness
- Irritability
- Poor appetite
- Disturbed sleep, sometimes marked by vivid dreams
- Gastrointestinal upsets
- Night sweats
- Tremor

Observation and monitoring

Patients should be observed every three to four hours to assess for complications such as worsening anxiety and dissociation, which may require medication.

As cannabis withdrawal is usually mild, no withdrawal scales are required for its management.

Management of cannabis withdrawal

Cannabis withdrawal is managed by providing supportive care in a calm environment, and symptomatic medication as required (Table 3).

There is some evidence that lithium carbonate may be an effective medication for cannabis withdrawal management. However, until further research has established the efficacy of the medication for this purpose, it is not recommended for use in closed settings.

Follow-up care

The preferred treatment for cannabis dependence is psycho-social care. Patients who have been using large amounts of cannabis may experience psychiatric disturbances such as psychosis; if necessary, refer patients for psychiatric care.


PART FIVE
Psychosocial interventions

5.1 INTRODUCTION

This section will focus on how you can help patients to learn how to remain abstinent after leaving closed settings. Two psychosocial interventions are provided: a brief intervention, consisting of four sessions of skills training, and an extended intervention that builds on these four sessions with a further three sessions.[10]

These interventions are designed to be used in one-on-one treatment sessions, but may be adapted for use with small groups of up to 12 patients. Some of the sessions require patients to read or write; healthcare workers may need to adapt these for patients who have poor literacy.

Essentials for conducting psychosocial interventions

Staff training

The psychosocial interventions should be provided by staff with qualifications in psychology, social work or other healthcare disciplines. There should be a clear separation between these staff, and staff who are employed to provide security for the closed setting.

Accept that different people have different treatment needs

Most people who use drugs do not experience any negative consequences. Not everyone who is in a closed setting is going to be dependent on drugs. Some patients will be dependent, but others will not. Patients who are not drug dependent do not need the same intensity or type of intervention as those who are.

Don't tell the patient what to do

It is not the purpose of psychosocial interventions to tell the patient what to do. Only the patient can decide what is best for him or her. Your role is to help the patient develop skills to think about and modify their behaviour.

Often patients will ask a question such as "What would you do?" or "What do you think I should do?". In instances such as these, gently redirect the conversation back to the patient by saying something like "It doesn't matter what I would do, because I'm not you. Only you can determine what's best for you".

Maintain a respectful, non-judgmental attitude

Patients may have been involved in activities that you disapprove of, including crime, sex work and illegal drug use. It is essential to remember that it is the activity you disapprove of, not the patient. You should always demonstrate respect for the patient. Avoid using words that insult or label the patient, like 'addict', 'criminal' or 'prostitute'. Shaming or upsetting a patient will not help them.

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[10] This concept has been adapted from Lee, N. et al. Methamphetamine Dependence and Treatment. Melbourne: Turning Point Alcohol and Drug Centre.

Encourage the patient to talk

Many of the treatment sessions in the psychosocial interventions involve the patient talking about their problems. Generally, you should talk less than the patient. Encourage the patient to talk by asking open-ended questions. These are questions that require more than a 'yes' or 'no' response. For example:

- Can you tell me about yourself?
- Can you tell me about your drug use?

Listen carefully to how the patient answers these questions and ask follow-up questions.

Acknowledge and praise positive change

Many drug dependent people feel unable to help themselves. An important part of drug treatment is giving the patient confidence and skills to solve their problems. You can do this by focusing on the patient's abilities. Show that you believe they are capable of changing their drug use and encourage the patient to believe the same. Acknowledge positive changes in the patient by using praise and small rewards.

Maintain confidentiality

As discussed previously, confidentiality is essential to ethical and effective treatment. Although sometimes very difficult in closed settings, discussions between a patient and healthcare worker are private and must be kept confidential. A person who has committed a crime or is dependent on drugs is still entitled to privacy and confidentiality.

Involving families in psychosocial interventions

It can be helpful to involve the patient's family in some treatment sessions, particularly drug education and release planning sessions. However, families should only be involved if the patient gives his or her permission. There are some important things to remember before involving a patient's family in treatment:

- The patient has the right to determine who is involved in treatment. If the patient does not want a particular family member involved in treatment, they should not be permitted to attend treatment sessions. Some patients will come from families that are violent and abusive. Do not involve a family member who is abusive towards the patient.
- Ask the patient who they consider to be their family - don't assume to know who the patient considers their family. Different people have different ideas about what makes up a family. For some patients it will be parents and siblings; for others it might be grandparents; for others a group of friends may be more important than relatives. Some patients may have a spouse, boyfriend or girlfriend that they want to involve in treatment. Remember that some patients will have same-sex partners.
- Family members who attend treatment sessions should be told that they must not use the treatment session to express anger or hostility towards the patient, and that they must not criticise or humiliate the patient. It is the healthcare worker's responsibility to make sure family members do not do these things.

5.2 BRIEF PSYCHOSOCIAL INTERVENTION[11]

This brief intervention consists of four sessions:

- Drug education
- Drug refusal skills
- Relaxation training
- Release planning

It is designed for people who are experiencing low levels of drug-related harm. The first session, on drug education, can be used on its own with people who use drugs but do not need ongoing intervention.

Drug education

Objective

To provide patients with accurate information about drugs, drug dependence and treatment.

Rationale for patient

By understanding more about how drugs interfere with the brain, you can get a better understanding of how to cope with cravings for drugs.

Method

There are a number of key concepts to discuss with patients. Don't just say these things to patients – ask the patient what he or she thinks about what you are saying and how it relates to their own experiences.

Discuss the various drug types, both legal and illegal. Describe the way that different drugs affect the central nervous system (see p.6). Mention that many people use drugs and experience no problems. However, some people experience harm when they use drugs, and some people become dependent on drugs. Using drugs or being drug dependent does not mean the patient is a bad or weak person. If a person is drug dependent, they have a medical problem that needs specialised treatment.

Discuss the signs of drug dependence, such as tolerance and withdrawal. Point out that if a person doesn't experience these symptoms, they are probably not dependent on drugs.

Explain that drugs cause temporary changes in the way a person's brain works. For a drug dependent person, this means that he or she may experience cravings for drugs for weeks or even months after they have stopped using them. However, these cravings will get less frequent and less intense over time, and will eventually go away completely.

Sometimes, cravings are very difficult to resist and the person may use drugs again – he or she may relapse. To avoid this, it is important to develop skills and strategies that the patient can use in their daily life. You will discuss some of these skills and strategies with the patient over the remaining sessions of this intervention.

[11] The skills and strategies discussed in the brief and extended psychosocial interventions are adapted from Jarvis, T., et al. (2005). Treatment approaches for alcohol and drug dependence (2nd edition). Sussex: Wiley & Sons and Lee, N. et al. Methamphetamine Dependence and Treatment. Melbourne: Turning Point Alcohol and Drug Centre.

Drug refusal skills

Objective

To provide patients with the self-confidence and skills to assertively refuse offers to use drugs.

Rationale for patient

Explain to the patient that, once released (or even while in the closed setting), they will almost certainly find themselves in a situation where they are offered drugs. It can be hard to say no in some situations, so we are going to help you to develop their confidence and ability to refuse offers of drugs.

Method

Saying “no” assertively isn’t just about the words you use – it’s also about body language and tone of voice.

We communicate a lot through our body language – how we stand or sit, and whether we make eye contact. One of the most important things to remember when refusing drugs is to look at the person directly when speaking so that they know you are serious about what you are saying.

Similarly, you need to use a firm tone of voice that communicates you are serious.

Once you have the right body language and tone of voice, there are some simple things that you can say to refuse drugs.

Say no first: A simple, “no thanks”, delivered in a firm tone of voice, is the best thing to say first.

Then, suggest an alternative activity. For example, going for a walk, or playing a game. If you are trying to avoid alcohol, suggest going to get a coffee instead of going to drink beer.

Sometimes, people can be quite persistent in pushing you to take drugs. They might say something like “go on, just like we used to”. You need to be assertive and ask the person to stop encouraging you to use drugs. Say that you can only be friends with the person if they respect your choice not to use drugs.

Changing the subject of conversation is important too. After saying no, ask the person how he/she has been lately, or how their family are.

Finally, avoid excuses and vague answers. In some cultures, it is difficult to be assertive in communicating your needs, but you will probably run out of excuses eventually, and vague answers give people the opportunity to keep pushing you to use drugs. It’s better to be direct. Remember, you don’t have to make excuses for not using drugs – it’s your right to say no.
In group therapy sessions, it can be useful to ask patients to get into pairs and take turns at refusing drugs.

Relaxation training

Objective

To provide patients with the ability to recognise physical and psychological tension, and how to reduce this tension for improved well-being.

Rationale for patient

Most people experience anxiety, stress or tension at some stage in their lives. Some people use drugs to cope with these negative feelings. Relaxation training is about learning how to recognise when you are tense, and how to reduce tension and maintain psychological well-being without using drugs.

Method

Ask the patient to identify situations or feelings that produce tension or anxiety for him or her. Examples might include relationship or family problems, money difficulties, or negative feelings like boredom, sadness or anger.

It's normal to feel tense or anxious occasionally, but sometimes people let their anxiety overwhelm them, and they may use drugs or alcohol to cope. A more productive way of coping is to practice relaxation.

Ask the patient if he or she already uses any sort of meditation or other psychologically calming practices such as yoga or tai chi. If so, encourage the use of these practices in addition to the relaxation training you will provide. Also encourage the patient to practice relaxation regularly – at least once a day. This will mean finding a quiet place where the person can sit or lie down comfortably, alone, and focus on relaxation.

The technique described below is called **progressive muscle relaxation**. It takes around 15-20 minutes. Use the following script as a guide for what to say to the patient. Speak slower than you would in normal conversation and use a gentle, quiet, soothing voice. The * symbol throughout this script represents a pause; pause silently for approximately five seconds per symbol. Pause for 15-20 seconds after each muscle group is relaxed, before moving onto the next muscle group.

> "Please take off your shoes and sit (or lie on your back) comfortably. Have your legs uncrossed and arms comfortably by your sides. Now, breathe slowly and deeply through your nose.
>
> I'm going to ask you to tighten particular muscles, then relax them. Tense the muscles for around five seconds, then relax the muscles for about ten seconds.
>
> Start with your feet. Curl your toes downwards and tense your feet muscles for one, two, three, four, five. Now, relax those muscles. Feel the tension slipping away and your breath getting slower. Focus on the sensation of your body relaxing *.
>
> Now tense your lower legs. Pull your toes towards you to stretch the calf muscles for one, two, three, four, five. Now relax your lower legs, feel the tension release from your legs**.

Tighten your thigh muscles *. Relax, focus on the pleasant feeling of relaxation and warmth in your body. **

Squeeze and tense your buttock muscles *. And now relax. Breathe slowly and deeply, feeling more and more relaxed*.

Tense your stomach and chest muscles *. Relax, feeling all the tension drain away from your body **.

Make a fist with each hand and tense the muscles in your forearms *. And relax **.

Tense the muscles in your upper arms. * And relax. **

Next, tense the muscles in your back. Push your shoulder blades together. * Now relax the muscles, feeling all the tension in your back loosen and leave your body **.

Carefully tense your neck *. And relax **.

Tense your jaw *. Now relax, as all the tension in your jaw and neck reduces **.

Squeeze your eyes shut and tense the muscles in your forehead *. Now relax your forehead and eyes **.

Continue breathing slowly and deeply. Tense your whole body and hold for a few seconds. * And now relax your whole body. Lie quietly for a few moments, feeling how relaxed your body is."

Allow the patient lie quietly in this relaxed state for at least five minutes, longer if possible. Then,

"Now, slowly become aware of your surroundings. Gently move your fingers and toes, arms and legs. Slowly open your eyes and sit up."

Encourage patients to practice progressive muscle relaxation, or other relaxation techniques, on their own.

Release planning

Objective

To encourage patients to plan their release from the closed setting in a way that minimises the risk of relapse.

Rationale for patient

Returning to your home and community is a stressful time, and it is common for people to begin using drugs again. One way to avoid this is to carefully plan exactly what you are going to do when you leave – where you will go, what you will do during the day and so on.

Method

To help patients most effectively, the counsellor needs to have a good understanding of local organisations that can help drug users. It is important that you are very familiar with a range of local services:

- Support groups
- Peer-based organisations
- Drop-in centres
- Services for homeless people
- Drug treatment providers, including methadone maintenance treatment providers
- Free or low-cost medical clinics
- Harm reduction services

Ask the patient to consider the practical, everyday issues they will face when they leave the closed setting:

- Where will you live?
- Do other drug users live there? How will this affect you?
- How will you earn money for essentials like food and clothing?

Also encourage patients to think about how they will avoid illicit drug use:

- Boredom is a big problem for many people trying to remain abstinent. What will you do to keep busy?
- What will you do if you become stressed, anxious or angry? What strategies will you use to cope with negative feelings?
- It is important to be able to talk to people who support your abstinence, including other former drug users. Do you know and can you contact any former drug users who are now abstinent? Is there a local meeting of Narcotics Anonymous or other support group that you can attend?
- What drug treatment options can you access once you return to the community? If you are currently on methadone maintenance treatment, have you discussed with your doctor if and how you can transfer to a community-based methadone program?

When discussing these issues, emphasize that it is possible for patients to address these problems and avoid relapse. If you are negative or pessimistic, patients may believe they will be unable to cope with returning to the community.

Assist the patient to write their own release plan. It should include:

- How they will make sure that their essential needs – food, shelter, income – will be met.
- How they will cope with high-risk situations.
- Support services they can access. These may include support groups, peer organisations, methadone maintenance treatment services and other drug treatment services. **Provide specific information** such as names of doctors or counsellors and contact details such as telephone numbers or addresses. Also provide practical assistance, such as helping patients to contact services before they are released. For example, let patients use a telephone in the closed setting for contacting drug treatment services. If the patient is on methadone maintenance treatment, assist the patient to transfer to a community methadone clinic. This will require liaison between the doctor in the closed setting and a doctor in the community.
- Harm reduction services they can access in case of one-off occasions of drug use or

relapse to regular drug use, for example, outreach services and needle and syringe programs. Again, provide contact details. In an ideal world, patients would not need to consider this information. However, it must be remembered that any patient may relapse. If they do, it is essential that they be able to access sterile needles and syringes.

5.3 EXTENDED PSYCHOSOCIAL INTERVENTION

The extended psychosocial intervention consists of the four sessions described in the brief psychosocial intervention, and an additional four sessions:

- Exploring motivation to change drug using behaviours
- Cognitive therapy
- Problem solving skills
- Craving management

These four additional sessions are for patients who are experiencing greater levels of drug-related harm, including drug dependence. Complete the brief psychosocial intervention sessions before moving on to these sessions.

Exploring motivation to change drug using behaviours

Objective

To increase the patient's motivation to reduce or cease their drug use.

Rationale for patient

It can sometimes be difficult to stop yourself from using drugs, especially if you still enjoy using drugs sometimes. In this session, we're going to talk about some things that will help you to be more aware of how your drug use affects you and the people around you.

Method

In this session, you will guide the patient through a discussion of different aspects of drug use. Encourage the patient to talk freely but keep the discussion focused. Discussing these things can be quite difficult for some patients. Allow plenty of time for the discussion and don't interrupt the patient because you want to move on to the next topic. Allow the conversation to move naturally from one topic to the next.

First, discuss the positives and negatives about using drugs. For example you could ask the patient:

- What are some of the things you enjoy about using drugs?
- What are some of the things that you don't enjoy about using drugs?
- Do you think the good things about using drugs outweigh the things you don't like about using drugs?

The next area of discussion may be the health risks associated with drug use. For example:

- Do you think that drug use has affected your health? In what way/s?

- If the patient is an injecting drug user, discuss some of the risks associated with injecting. As well as HIV infection, this could include discussion of hepatitis C infection, collapsed veins, endocarditis (infection of heart valves) and abscesses.
- Do you think that drug use has affected your mental health? In what way/s?
- Are you concerned that drug use may affect your health?

The financial costs of using drugs can be very high.

- How much money do you spend on drugs?
- Are there things that your money could be better spent on?

An interesting technique is the 'looking back/looking forward' discussion.

- Can you tell me a bit about what your life was like before you began using drugs?
- How has your life changed since you started using drugs?
- How have you changed since you started using drugs?

The aim of this discussion is to encourage the patient to think about reasons for why they might want to change their drug use. The next step is to assist the patient to identify how they might go about changing their drug use.

First, summarise what the patient has talked about during the above conversation, and then provide the patient with an opportunity to state the need for change. For example,

- What do you think you could do about these things we have talked about?

Often, the decision to change drug use can be difficult. The patient may be worried about losing friends, or difficulties they will have to face when they stop using drugs. Explore these worries and provide reassurance. For example,

- Is there anything that scares you or worries you about not using drugs?

Finally for this session, assist the patient to set some goals for behaviour change. Remember, these have to be the patient's goals, not yours. Some patients may wish to be abstinent from all drugs, while others may just want to reduce their drug use to a more manageable level. Either way, it is important that the goals the patient sets are realistic and obtainable. For example,

- What is your overall goal in relation to your drug use?
- Sometimes it helps to set smaller goals that are steps on the way to a bigger goal. What are some of the smaller goals that you could set on the way to achieving your overall goal?

Cognitive therapy

Cognitive therapy involves teaching the patient to:

- Identify thoughts or feelings that lead to drug use, and
- Challenge these thoughts so as to avoid drug use

Cognitive therapy can be very useful, but it uses concepts that can be difficult for some patients to grasp. Patients who are not used to "thinking about thinking" (i.e. analysing how they process thoughts and ideas) can find cognitive therapy difficult to understand.

Objective

To provide patients with the skills to

- Recognise negative or unreasonable thought patterns
- Interrupt negative thought patterns and replace them with more realistic thoughts

Rationale for patient

Explain to the patient that thinking influences the way we feel and behave. That is, the way we interpret a situation affects how our emotions and behaviour.

As an example, imagine you have just knocked over a bucket of water. Some people would respond to this by thinking things like “I’m such an idiot” or “I’m totally useless”. This then leads to them feel that sad or angry. So, an event occurred, the person interpreted it and that made them feel upset.

What we will now do is learn how to identify unhelpful thoughts or interpretations of events, and how to challenge and change your thoughts so that you feel better about yourself.

Method

Identifying negative thinking

The first step is help the patient identify when they are thinking in negative or unhelpful ways. Have the client identify a situation where they felt strong negative emotions. Break down the situation into the **event**, the **thoughts** the patient had about the event, and the **feelings** they experienced as a result of their thoughts. For example:

Event	Thoughts	Feelings/behaviour
e.g. Lost my keys	“I’m an idiot”	Angry with self, got angry at my children

This process can take some time. The main goal at this stage is to get the patient to understand that their **feelings are not caused by events; their feelings are caused by how they think about events**.

Once the patient understands the basic concept, introduce the idea of **thought monitoring.** This involves the patient keeping a written record of negative thoughts, and how they made him/her feel, using the **Though Monitoring Sheet** on page 69. Ask the patient to keep a record of negative thoughts for several days.

Challenging negative thinking

Once the patient is able to identify negative thoughts, the next step is to challenge those thoughts and modify them to be more positive or realistic.

The patient may have noticed some patterns in the negative thoughts they have recorded. There are four main types of negative thoughts:

Rigid, all-or-nothing thinking. For example, a musician might make one mistake during a performance, but thinks to himself “I *always* make mistakes”.

Over-exaggerating the consequences of negative events. For example, after

making a mistake the musician might think “That was a disaster, I’ll never be hired to play again”.

Low frustration threshold. This is an inability to deal appropriately with stress or difficult situations. For example, after making a mistake the musician might think “I can’t take this anymore, this is too difficult, I quit”.

Depreciation thoughts. These are thoughts that undervalue the self. For example, after making a mistake the musician might think “I am useless, the worst guitar player ever”.

Ask the patient if he/she has noticed these negative thought patterns in their own thought monitoring. Discuss the patient’s thought monitoring sheet and the negative thoughts that have been recorded.

Next, teach the client how to challenge negative thoughts. Challenging negative thoughts is done by asking four questions about the thought:

What is the evidence for and against what I am thinking? That is, help the patient to understand that there may be a difference between real events and the way the patient is interpreting the events. For example, the musician who made one mistake and thought “I *always* make mistakes” could look at the rest of his performance and say “well, actually, I only made one mistake the whole time I was playing, so I don’t always make mistakes”.

What are the advantages or disadvantages of thinking this way? Some negative thoughts occur because they actually have advantages for us. For example, the musician might think “I will never be hired to play again”, because that way he can be excited when he is hired again. Help the patient to identify the reasons why they might be thinking the way they do.

Is there a thinking error? Give the patient the handout **Common thinking errors** (p.70). Do the patient’s negative thoughts correspond to one of the thinking errors?

What are some alternative ways of thinking about the situation? Have the patient come up with some different thoughts about the event. It can be helpful to ask the patient what a friend might have thought in the same situation. Also give the patient a copy of the handout **Strategies for challenging negative thoughts** (p.71).

It’s important to emphasise to the patient that the object of cognitive therapy is not to make the person deliriously happy all the time. Sometimes, it is appropriate to feel upset or distressed. The aim of cognitive therapy is to identify situations where the patient’s response is overly negative, and modify that response to improve psychological well-being.

Thought monitoring sheet

Describe the situation	*What were your thoughts?*	*How did your thoughts make you feel?*

Common thinking errors[12]

'All or nothing" thinking:

Thinking that things are either great, or terrible. For example,
If I don't do well in this exam, I will be a failure at everything in life

Overgeneralisation:

Expecting that because something has gone wrong once, it will always be the case that everything goes wrong. For example,
I relapsed last time I stopped using drugs, so I'll probably always relapse

Mental filter:

Only seeing the negative things and focusing on them, so that it distorts how you see situations or people. For example,
He let me down last time I needed him. He must not care about me at all

Changing positives into negatives:

Rejecting your positive achievements by making up excuses. For example,
I didn't relapse, but that was only because my father was around.

Reaching negative conclusions:

Drawing a negative conclusion when there is no evidence to support it. For example,
I know they won't want to talk to me, so why should I try to participate?

Over-exaggerating negative consequences:

Exaggerating the consequences of an event. For example,
If I don't get the highest test score in the class, everyone will laugh at me

Mistaking feelings for facts:

Confusing what you feel with the true situation. Just because you feel something, doesn't mean it's true! For example,
I feel like an idiot does not mean you really are an idiot

Personalising:

Blaming yourself for anything that is unpleasant or goes wrong. For example,
She looks angry – it must be something I have done.

Putting yourself down:

Undervaluing yourself as an extreme over-reaction to a situation. For example,
Well, I don't deserve any better for being so stupid

[12] Jarvis, T., et al. (2005). Treatment approaches for alcohol and drug dependence (2nd edition). Sussex: Wiley & Sons.

Strategies for challenging negative thoughts[13]

Ask yourself: "Am I over-reacting?":

Is the event or situation really as bad as you think? How likely is it that the worst will happen? How could you cope if the worst really did happen?

Think hopefully:

Be kind and encouraging to yourself. Say hopeful things to yourself like "Even though it's difficult, I can do this", or "things can change, it won't always be like this"

Blame the event, not yourself:

Everyone makes mistakes. A mistake does not mean you are totally worthless or stupid.

Focus on taking action:

Focusing on your problems will only make you feel worse. Instead, focus on what you need to do to solve your problems.

Be more reasonable in your expectations:

Don't expect yourself or other people to be perfect all the time. Understand that you might make mistakes, and that you can't please everybody all the time.

Focus on good things:

What good things have happened recently? What do you like about yourself? What skills do you have that allow you to cope with difficult situations?

Problem-solving skills

Objective

To teach patients:

- To recognise when problems exist
- To recognise that problems can have multiple solutions
- How to select and enact the most appropriate solution to a problem
- How to evaluate if the solution was effective

Rationale for patient

Everyone faces problems in their daily life, such as difficulties with family relationships or difficulty earning enough money. Sometimes, people take drugs to forget about or avoid their problems. But, this doesn't fix the problem. When you are released, problems like these might be something that leads to you using drugs again. To help prevent that, we're going to discuss a simple method for analysing and solving problems.

[13] Jarvis, T., et al. (2005). Treatment approaches for alcohol and drug dependence (2nd edition). Sussex: Wiley & Sons.

Method

Before beginning, provide patients with the handout 'Six steps of problem solving' (p. 74).

The first step in problem solving is to define the problem. It is easiest to define the problem in terms of why the problem has occurred, or when the problem occurs. Have patients select a problem situation. It may be related to drug use, or it may be related to other difficulties, such as employment, friends, family or finances. If the patient is having trouble identifying a problem, prompt him/her by asking about situations when they feel uncomfortable or negative – this is a good sign that there is a problem.

Have patients define their problem in the appropriate section of the handout. If the problem is large, break it down into smaller, more manageable problems and apply the problem solving technique to each. Define exactly what the problem is.

For example, a patient may nominate his or her drug use as a problem. This can be broken down into smaller problems, such as

I use drugs to cope with anxiety
I am worried I won't have any friends if I don't use drugs
Drug use is costing me a lot of money

Once the patient has defined a problem, ask them to 'brainstorm' different solutions to the problem. At this stage, there is no criticism of the solutions and no solution is ruled out. Have the patient write down all the potential solutions in the appropriate section of the handout. If the patient is having trouble thinking of solutions, have them think about what they would recommend to a friend with the same problem.

The next step is to choose the most appropriate solution. The patient has to choose the solution that is best for him or her. The patient might choose a different solution to what you would choose. You must let the patient choose the option that they believe is best for them.

Once a solution has been chosen, it's time to develop an action plan. This involves breaking down the solution into small steps. For example, if a patient has decided that "learn how to make traditional crafts" is the solution to their problem, the action plan may be:

Ask my parents and parent's friends if they know anyone who teaches traditional crafts
Use the internet to find a place that teaches traditional crafts
Enrol in a class or ask someone to teach me
Attend all my classes and practice at home

Get the patient to write their action plan in the appropriate section of the problem-solving handout.

The next step is to undertake the action plan. This may not be practical in a closed setting, but at least the patient has prepared what they may be able to do after release.

The final step of problem solving is to evaluate the solution. Has the problem been resolved? It may be necessary to go through the problem solving steps again until an effective solution is reached.

Six steps of problem-solving

<table>
<tr><td colspan="4">Step 1. My problem is….</td></tr>
<tr><td colspan="4">Step 2. Possible solutions are…</td></tr>
<tr><td rowspan="3">Step 3</td><td colspan="3">Positives and negatives of each solution</td></tr>
<tr><td>Possible solution</td><td>Positives</td><td>Negatives</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">The solution I choose is…</td></tr>
<tr><td colspan="4">Step 4. My action plan</td></tr>
<tr><td>Step 5. Carry out my action plan</td><td></td><td></td><td></td></tr>
<tr><td>Step 6. How well did my action plan work to solve the problem?</td><td></td><td></td><td></td></tr>
</table>

Craving management

Objective

To provide the patient with skills in understanding cravings and how to effectively manage cravings.

Rationale for patient

It is normal to experience a strong desire to use your drug of choice. This is called a **craving**. In this session we are going to talk about how you can manage cravings to reduce the risk of relapse.

Method

There are three components to craving management – recognising, avoiding and coping.

First, explain the nature of cravings to the patient. Cravings happen because of cues – situations or feelings that make you want to use drugs. However, if the patient is able to ignore the cravings, they will become weaker and less frequent over time.

There are different types of cues that may trigger cravings.

- External cues: these are locations (e.g. nightclubs), people (e.g. drug-using friends) or situations (e.g. having extra money) that are associated with using drugs.
- Internal cues: these are thoughts or feelings that are associated with using drugs. For example, the person may associate looking forward to going out with using drugs.

Ask the patient to identify their own craving cues. It is important that the patient identifies their own cues, not just ones that you mention. If the patient is unable to identify any cues, ask questions such as:

- What people were around the last time you wanted to use drugs?
- Where were you the last time you wanted to use drugs?
- How were you feeling the last time you wanted to use drugs?
- Do you think these people/situations/feelings may be craving cues?

The next step is to ask the patient to describe their own cravings. Ask about the following:

- Physical symptoms during the craving
- Thoughts during the craving
- Intensity of the craving
- Duration of the craving
- Level of discomfort experienced

What does the patient currently do during cravings? Is he or she already using some coping strategies? If yes, provide positive reinforcement.

After developing an understanding of the patient's cravings and the external and internal cues that trigger this patient's cravings, move onto cue avoidance. Learning to avoid cues is an important part of maintaining abstinence. Some avoidance strategies include:

- Reducing contact with friends who use drugs
- Avoiding places where drugs are readily available

- Getting rid of any remaining drugs the patient has at home or hidden elsewhere
- Staying away from places where the patient used drugs

Although avoidance is a good start for managing cravings, it cannot be the only strategy the person uses. The patient needs to develop a range of other strategies that can be called on when a craving begins.

Some commonly used coping strategies include:

- **Distraction**: Discuss enjoyable activities that the patient can undertake to distract away from the craving to use drugs. Have the patient develop a list of activities that can be used to distract. Examples may include going for a walk or a bike ride, reading, or creative activities such as drawing or writing.
- **Sharing**: Discussing the craving with a trustworthy person can be very useful – it allows the patient to talk about the craving without giving in to it. Help the patient to identify people who may be able to help in this regard. They may be close friends who don't use drugs, family members, or other former drug users.
- **Positive self talk:** Assist the patient to identify some short, positive messages that can be repeated when a craving occurs. For example, 'I can cope with this' or 'this is temporary and I will get over this feeling soon'.
- **Think about consequences of drug use:** When a person is craving drugs, it is very easy to minimise the negative consequences of drug use and think only about the positive things about using drugs. Explain to patients that during cravings, they should try to think rationally about drug use. That is, they should balance the positives – e.g. I will feel better – with the negatives e.g. I will spend all my money, I might be arrested.

It can be helpful for the patient to write down some of their external and internal cues, and how they plan to cope with these. Encourage the patient to write this down and carry it around with them so that they can refer to it as needed.


PART SIX
Methadone maintenance treatment

6.1 INTRODUCTION

Methadone is an opioid, like heroin or opium. Methadone maintenance treatment has been used to treat opioid dependence since the 1950s.[14] The opioid dependent patient takes a daily dose of methadone as a liquid or pill. This reduces their withdrawal symptoms and cravings for opioids.

Methadone is addictive, like other opioids. However, being on methadone is not the same as being dependent on illegal opioids such as heroin:

- It is safer for the patient to take methadone under medical supervision than it is to take heroin of unknown purity.
- Methadone is taken orally. Heroin is often injected, which can lead to HIV transmission if needles and syringes are shared.
- People are heroin dependent often spend most of their time trying to obtain and use heroin. This can involve criminal activity such as stealing. Patients in methadone do not need to do this. Instead, they can undertake productive activities such as education, employment and parenting.

Methadone has been included on the World Health Organization's List of Essential Medicines. This highlights its importance as a treatment for heroin dependence.

There has been a great deal of research on MMT. This research has found that

- MMT significantly reduces drug injecting;
- because it reduces drug injecting, MMT reduces HIV transmission;
- MMT significantly reduces the death rate associated with opioid dependence;
- MMT reduces criminal activity by opioid users; and
- Methadone doses of greater than 60mg are most effective.[15]

In closed settings, MMT should be available to patients who have been receiving MMT in the community and wish to continue this treatment in the closed setting, and patients with a history of opioid dependence who wish to commence MMT. Patients should receive MMT for the entire duration of their detention in the closed setting. This ensures the maximum benefits of the treatment are obtained.

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[14] Buprenorphine is another medicine used as a substitute for heroin in the treatment of opioid dependence. However, these guidelines will focus on methadone as it is the most widely used substitute medicine.
Another medication sometimes used for treating opioid dependence is naltrexone, which blocks the effects of opioiods; however there is very little evidence that this is effective, and it is not recommended for use in closed settings

[15] WHO/UNODC/UNAIDS. Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Geneva: World Health Organization, 2004.

Case study: The Hong Kong Methadone Maintenance Program

Hong Kong has had a methadone maintenance treatment program since 1972. The program was started in response to rising levels of drug use. More recently, the program has been crucial to controlling the HIV epidemic. Hong Kong methadone clinics have several important characteristics that make them easy for drug users to access:

- Low cost of treatment – HK$1 (about 12 US cents) per clinic attendance
- Open seven days per week and are open from early in the morning to late at night
- Operate on a "low threshold" model – this means that there are few conditions that patients must meet to begin treatment
- Non-judgemental approach that includes providing harm reduction information and condoms

Research conducted with patients of the Hong Kong methadone program has shown that patients who attend the clinic regularly show reduced levels of drug injecting and HIV risk behaviours. It has also been shown that patients receiving methadone doses of greater than 60mg per day were less likely to use or inject drugs than patients receiving doses of less than 60mg per day.

Rationale for MMT in closed settings

In countries where MMT is available in the community, it should also be available in prisons. This is in line with the public health approach to HIV prevention and the principle of equivalence of care.

MMT is provided to inmates in prisons in at least thirty countries, including Australia, Canada, Indonesia, Iran, and Spain. There are several compelling reasons for providing MMT to opioid dependent patients in closed settings:

Reducing risks associated with injecting drug use

MMT in closed settings reduces drug injecting by prisoners. In Australia, a trial of MMT in prison found that despite being in prison, over 80% of inmates starting methadone treatment had used heroin in the previous month; however, after four months of treatment, only 25% of prisoners were still using heroin.[16] By reducing drug injecting, MMT reduces opportunities for HIV to be transmitted between prisoners.

Reducing risk of re-incarceration

Many drug users experience multiple episodes of detention in closed settings. However, patients who remain in MMT after leaving closed settings are less likely to return to closed settings than non-treated heroin users.[17]

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[16] Dolan K, Shearer J, MacDonald M, Mattick R, Hall W, Wodak A. A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. Drug and Alcohol Dependence 2003;72(1):59-65.

[17] Dolan K, Shearer J, White B, Zhou J, Kaldor J, Wodak A. Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration and hepatitis C infection. Addiction 2005;100:820-828.

Reducing the risk of relapse following release

People who leave closed settings often relapse to regular drug use within a few days or weeks of being released. Being in MMT in the closed setting and then continuing treatment in the community reduces the risk of relapse.

Case study: Methadone maintenance treatment in prison in Indonesia

Indonesia established a pilot methadone maintenance program in prison in 2005. The program was started as part of Indonesia's comprehensive HIV prevention strategy for prisons. Other components of the strategy include distributing condoms and bleach (for cleaning used needles and syringes) in prison and providing free antiretroviral treatment for HIV-positive prisoners.

Some of the patients in the methadone program are continuing treatment begun in the community, while others have started methadone treatment in prison. Patients who are HIV-positive receive free antiretroviral treatment in addition to methadone.

There are plans to expand the methadone maintenance program to other prisons in Indonesia. The success of this pilot program has demonstrated that it is feasible to introduce methadone maintenance treatment in resource-poor settings.

Required resources

Essential staff

Physicians

Only a medical doctor may prescribe methadone. A medical doctor should conduct the assessment on which the decision to prescribe methadone is based. Doctors also take part in treatment planning and treatment reviews.

Nurses

Nurses are required to conduct methadone dispensing and supervision of its consumption. Other roles for nurses in methadone maintenance treatment include:

- Taking part in treatment reviews and providing reports to clinic doctors
- Providing vaccinations (e.g. hepatitis A and B) and referring patients for infectious disease testing (e.g. HIV, hepatitis, sexually transmitted infections, tuberculosis)
- Attending to general health needs of patients, for example, dressing wounds and ulcers; assisting with general hygiene and infection control

Counsellors

Counsellors support medical staff of the treatment program by:

- Providing general counselling on issues of concern to patients
- Undertaking motivational interviewing with patients to increase motivation to reduce illicit drug use
- Providing pre- and post-test counselling for patients seeking testing for HIV or other infectious diseases

Other professionals

Although not essential, the following staff can also assist patients in methadone maintenance treatment:

Psychologists

Psychologists can assist patients suffering from co-morbid mental illnesses and psychiatric problems such as depression, anxiety or post-traumatic stress disorder.

Social or welfare workers

Social workers and welfare workers can provide general counselling and assist patients with practical concerns such as contacting their family or finding housing for when they leave the closed setting.

Community liaison officers

A community liaison officer is employed specifically to assist patients to transfer to community-based MMT programs on their release from the closed setting. This person may have skills or training in social or welfare work.

Facilities

Medical clinic

Methadone should be dispensed via a medical clinic within the closed setting. The clinic must be staffed and open to patients seven days per week. The clinic should be equipped with a dispensing pump or measuring cylinder for ensuring accurate methadone dosing, and should also maintain adequate supplies of basic first aid and resuscitation equipment.

Secure storage area

Methadone must be stored in a secure area within the medical clinic, for example, locked in a room or safe. It should not be obvious to patients that this is where methadone is stored.

Post-dosing supervision room

Following dosing, patients must move into a supervision room located next to or close to the medical clinic. This is to help prevent diversion of methadone to others. Patients in the supervision room must be monitored for around 15-20 minutes after dosing.

Effects of methadone

Methadone is a synthetic opioid agonist. This means it produces effects in the body in the same way as heroin, morphine and other opioids. It is taken orally as a tablet or syrup.

When an opioid dependent person takes methadone, it relieves withdrawal symptoms and opioid cravings; at a maintenance dose, it does not induce euphoria.

Onset of effects occurs 30 minutes after swallowing and peak effects are felt approximately three hours after swallowing. At first, the half-life (the length of time for which effects are felt) of methadone is approximately 15 hours; however, with repeated dosing, the half-life extends to approximately 24 hours. It can take between 3 and 10 days for the amount of methadone in the patient's system to stabilise.

Most people beginning MMT experience few side effects. However, there are some side effects of methadone, including:

- Disturbed sleep
- Nausea and vomiting
- Constipation
- Dry mouth
- Increased perspiration
- Sexual dysfunction
- Menstrual irregularities in women
- Weight gain

Interactions between methadone and other medications

Interactions between methadone and other drugs can lead to overdose or death. Drugs that depress the respiratory system (e.g. benzodiazepines) increase the effects of methadone. Drugs that affect metabolism can induce methadone withdrawal symptoms. Clinically important drug interactions are listed in Table 12 (p.83). In particular it is important to note interactions between methadone and medications used to treatment HIV and tuberculosis:

- The HIV medications **nevirapine** and **efavirenz** increase metabolism of methadone, causing opioid withdrawal. Some protease inhibitors (PIs) may have the same effect, especially when associated to a small boosting dose of ritonavir.
- The tuberculosis medication **rifampicin** increases metabolism of methadone and reduces the half-life of methadone.

Patients receiving these medications, or other medications listed in Table 12, in combination with methadone should be monitored for signs of withdrawal or intoxication, and their methadone dose adjusted accordingly. See also AIDSinfo, http://www.hivatis.org/, for up-to-date listings of antiretroviral medications and interactions with other drugs.

Patients in methadone maintenance treatment can become tolerant to the pain-relieving effects of opioids. In the event that an MMT patient requires pain relief, non-opioid analgesics such as paracetamol can be given. If methadone patients are provided with opioid analgesics, they may require higher than normal doses to experience pain relief.

Table 12: Methadone-medication interactions

Drug	Effect
Alcohol	Increased sedation and respiratory depression
Barbiturates	Reduce methadone levels, increased sedation and respiratory depression
Benzodiazepines	Increased sedation and respiratory depression
Buprenorphine	Increased sedation and respiratory depression OR antagonist effect
Carbamazepine	Reduced methadone levels
Chloral hydrate	Increased sedation and respiratory depression
Chlormethiazole	Increased sedation and respiratory depression
Cyclazine & other sedating antihistamines	May cause hallucinations
Desipramine & other tricyclic antidepressants	Increased desipramine levels
Fluoxetine, Sertraline & other SSRIs	Increased methadone levels
Ketoconazole	Increased methadone levels
Meprobamate	Increased sedation and respiratory depression
Naltrexone	Blocks effects of methadone (long acting)
Naloxone	Blocks effects of methadone (short acting) – may be required in case of opioid overdose
Nevirapine & other non-nucleoside reverse transcriptase inhibitors	Decreased methadone levels
Phenytoin	Decreased methadone levels
Rifampicin	Decreased methadone levels
Rifabutin	Decreased methadone levels
Ritonavir and other protease inhibitors	Decreased methadone levels
Thioridazine	Increased sedation and respiratory depression
Urine acidifiers e.g. ascorbic acid	Decreased methadone levels
Urine alkilisers e.g. sodium bicarbonate	Increased methadone levels
Zidovudine	Increased Zidovudine levels – risk of anaemia
Zopiclone	Increased sedation and respiratory depression
Other opioid agonists	Increased sedation and respiratory depression

Other central nervous system depressants	Increased sedation and respiratory depression

See also AIDSinfo, http://www.hivatis.org/, for up-to-date listings of antiretroviral medications and interactions with other drugs.

6.2 ENTERING TREATMENT

Indications

Methadone maintenance treatment is indicated for patients who are dependent on opioids or have a history of opioid dependence. In closed settings, it is important to remember that patients not currently physically dependent on opioids can benefit from the relapse prevention effects of methadone maintenance treatment.

Patients must also be able to give informed consent for methadone maintenance treatment.

Contraindications

Patients with severe liver disease should not be prescribed methadone maintenance treatment as methadone may precipitate hepatic encephalopathy.

Patients who are intolerant of methadone or ingredients in methadone formulations should not be prescribed methadone.

Priority patients

Patients who meet *any* of the following criteria should commence MMT without delay:

- HIV positive
- Receiving treatment for HIV or hepatitis C
- Patients who have been on community methadone maintenance treatment programs. In these cases, the patient should continue MMT in the closed setting at the dose that they were receiving in the community. It is very important that the patient's treatment is not interrupted unnecessarily; hence, the closed setting should have a procedure in place for people who are detained while on methadone.
- History of drug overdose in closed settings
- History of self-harm/suicidal behaviour in relation to opioid dependence
- Pregnant, opioid dependent women should commence methadone maintenance treatment as soon as possible. Pregnant women should be assessed and dosed in the same manner as other patients. Should a patient fall pregnant while in MMT, she can be maintained on her usual daily dose. In the last trimester of pregnancy, it may be necessary to increase the daily dose in order to adequately control withdrawal

symptoms. Babies born to mothers on methadone maintenance treatment may experience a withdrawal syndrome, which should be managed by a postnatal care specialist.

Risks and precautions

There are few risks associated with the long-term use of methadone. Methadone does not damage any of the major organs or systems of the body. There are few side effects of methadone and those that do occur are less harmful than the risks associated with illicit opioid use.

Overdose

The major risk associated with methadone is overdose. Overdose is a particular concern in the initial stages of MMT and when methadone is used in combination with other depressant drugs. Methadone overdose may not be obvious for three to four hours after ingestion. Patients should be closely monitored during the first week of treatment for signs of overdose, including:

- Pinpoint pupils
- Nausea and vomiting
- Dizziness
- Excess sedation
- Slurred speech
- Snoring
- Slow pulse and shallow breathing
- Frothing at the mouth
- Unconscious and unable to be roused

Overdose is more likely to occur if the patient is using other drugs that depress the central nervous system e.g. alcohol, benzodiazepines or opioids. Patients should be informed of the risks of using these drugs in combination with methadone.

In case of overdose, naloxone should be administered. This reverses the effects of methadone. Because methadone has a long half-life, it is necessary to provide a prolonged infusion or multiple doses of naloxone over several hours. Patients who have overdosed should be transferred to a hospital and monitored for at least four hours.

Ongoing poly-drug use

Methadone should be prescribed with caution to patients who are using other drugs, particularly those that depress the central nervous system (e.g. alcohol, benzodiazepines). Patients should be advised of the increased risk of overdose associated with using methadone in combination with other drugs.

Concurrent medical problems

Methadone should be prescribed with caution in patients with:

- Asthma and other respiratory conditions
- Hypothyroidism
- Adrenocortical insufficiency
- Hypopituitarism
- Prostatic hypertrophy

- Urethral stricture
- Diabetes mellitus

Informed consent and treatment planning

Before beginning MMT, the patient must be given enough information for him or her to make an informed decision about commencing treatment. The patient should be told:

- The rationale for methadone maintenance treatment
- The reasons it has been recommended to treat their opioid dependence
- Side effects and risks of treatment
- Expected length of treatment
- Other treatment options

As part of informed consent, tell the patient about the rules that must be followed to receive methadone treatment. For example:

- Patients consume their complete dose in front of dosing staff and do not give or sell any part of their dose to others.
- No violence or threats of violence against staff or other patients
- The patient is to attend consultations with their doctor as required
- Consequences for breaching these rules

The patient should be given a patient information statement containing all of the above information and asked to read it. If the patient cannot read, the patient information statement should be read aloud. A sample **patient information statement** is shown on page 89. If the patient is happy to begin treatment after this process, he or she should sign a consent form to this effect. A sample **consent form** is provided on page 90.

After obtaining informed consent from the patient, develop a treatment plan that outlines the patient's starting dose and the schedule by which doses will increase. See page 28 for more information about treatment plans.

The first dose

The first dose of methadone given to a patient is low. The size of the dose is gradually increased until the **maintenance dose** is reached. The maintenance dose is the amount of methadone the patient requires to prevent opioid withdrawal symptoms, but does not induce euphoria.

The first dose of methadone should be between 10-30mg. Patients who have recently used opioids can be given a first dose at the higher end of this range. The first dose given to a patient who has not recently used opioids should be no greater than 10-20mg. When determining the size of the first dose, keep in mind that deaths from methadone overdose in the first two weeks of treatment have occurred at doses as low as 40-60mg per day.

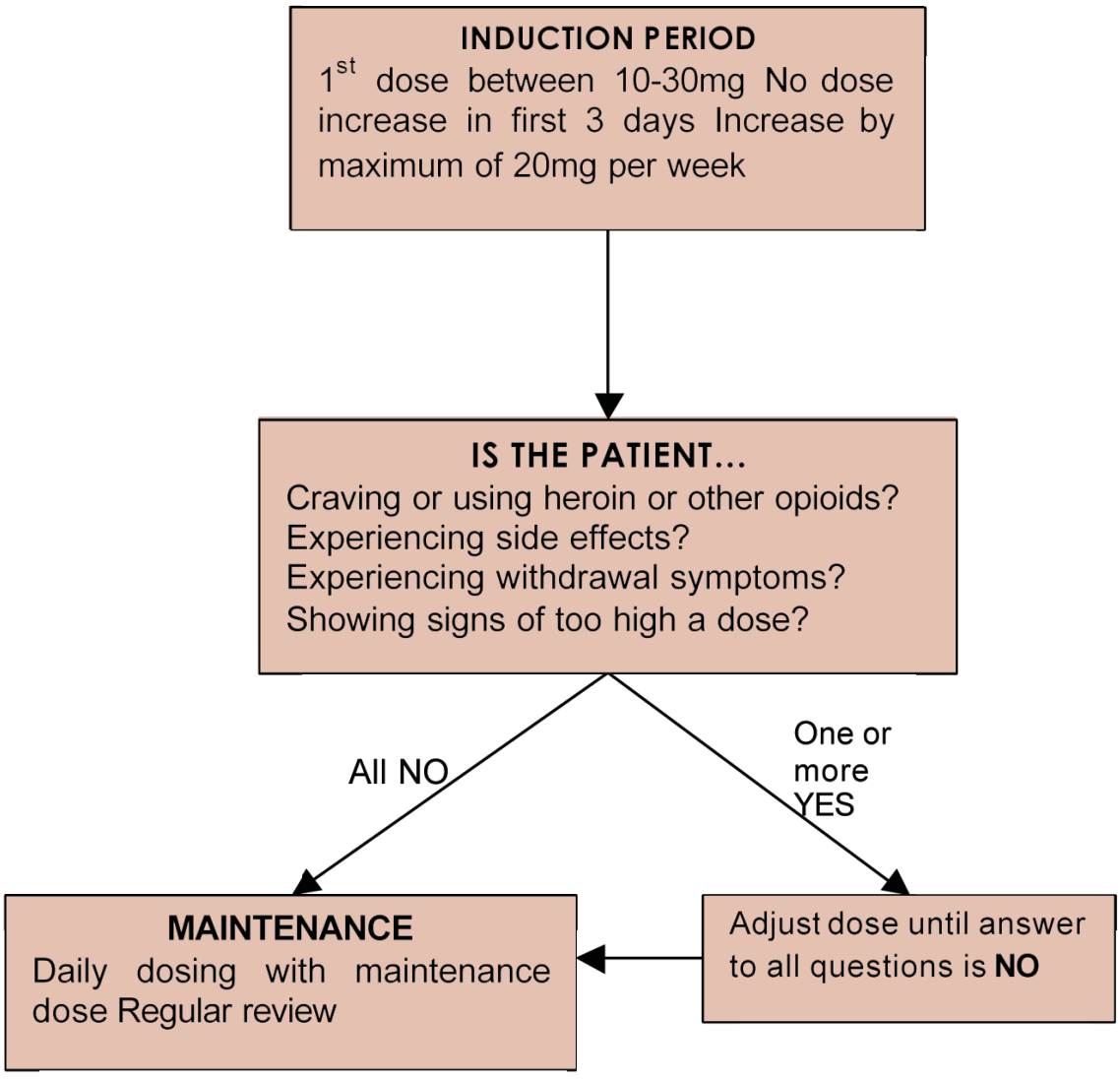
Observe the patient 3-4 hours after the first dose has been taken. If the patient is showing signs of overdose, continue to monitor the patient at fifteen minute intervals. If the patient enters a coma, administer naloxone as a prolonged infusion.

Provide the same dose daily for three days. The patient will experience increasing effects from the same dose over this time. After the first three days, assess the patient's withdrawal

symptoms. If the patient is experiencing withdrawal, increase the dose by 5-10mg every three days. Dose increases should not be greater than 20mg per week.

Monitor the patient for signs of withdrawal and intoxication and adjust the methadone dose accordingly to find the patient's maintenance dose. This process may take several weeks. The maintenance dose will usually be between 60-120mg, but may be higher or lower, depending on the patient's history of opioid use. See also Figure 3.

Figure 3: Methadone maintenance treatment dosing flowchart

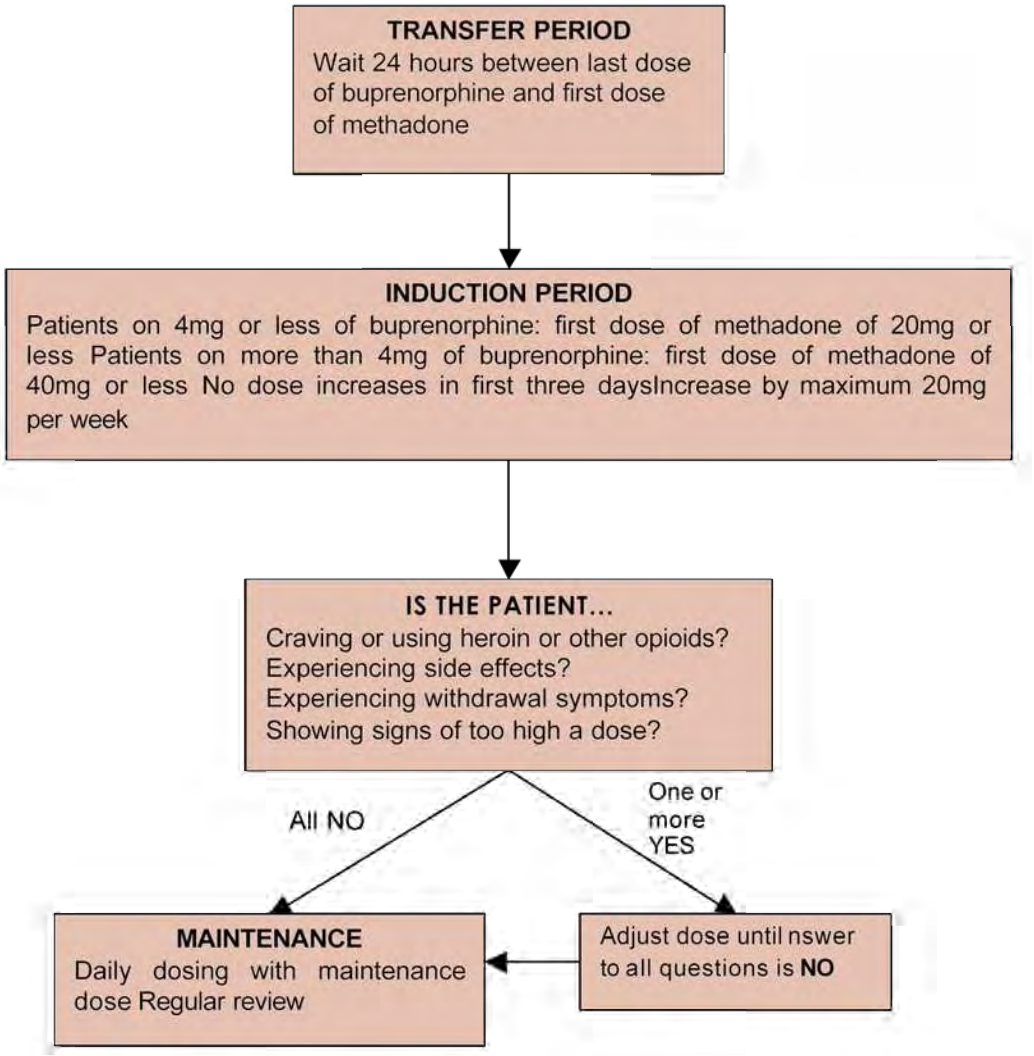


INDUCTION PERIOD

Patients who have been treated with buprenorphine

If a patient is detained who has been on buprenorphine maintenance treatment in the community, you should endeavour to assist the patient to continue this treatment. However, if buprenorphine is not available, the patient should be transferred to methadone maintenance treatment (Figure 4).

Figure 4: Methadone maintenance treatment flowchart: Patients transferring from buprenorphine maintenance treatment
Patient information sheet



Methadone is a medicine used to treat heroin dependence. It is taken daily to relieve heroin withdrawal symptoms and reduce cravings for heroin. The aim of methadone maintenance treatment is to help you reduce your illicit drug use. Before you begin methadone maintenance treatment, you should be aware of the following:

- Methadone is an opioid, like heroin. While in this treatment, you will still be dependent on opioids. But, taking methadone will be much safer than taking heroin. Taking methadone can give you a break from the drug-using lifestyle and give you a chance to work on any social, financial or family problems you are having as a result of your

drug use.

- Methadone maintenance treatment is a long-term treatment. Some people receive methadone for many months or even years. While in methadone maintenance treatment, you will need to attend the clinic once a day to receive your dose of medicine.
- Tell your doctor if you are taking any other medications or herbal remedies as these may interact with methadone, causing health problems.
- Some people experience side effects from taking methadone. These include constipation, nausea, feeling tired, perspiring more than usual, a dry mouth and feeling dizzy.
- If you begin methadone maintenance treatment, you must avoid taking other opioids such as heroin, codeine, morphine or opium. Taking these drugs in combination with methadone can lead to overdose, which can be fatal. If you drink alcohol, be sure to do so in moderation, as alcohol and methadone in combination can also lead to overdose.
- There are other drug treatment options available besides methadone maintenance treatment. Ask your doctor if you would like to know about these.

Should you begin methadone maintenance treatment at this clinic, you will be required to follow these rules:

- You must attend for dosing each day.
- You must attend treatment review sessions with your doctor regularly.
- You must not sell or give your methadone dose to anyone else. Your dose has been determined based on your level of opioid dependence. Other people may overdose if you sell or give them your dose. If you are being bullied or forced to give your dose to someone, tell a staff member of the clinic.
- You must not engage in any threatening or violent behaviour towards staff or other patients, or you will be removed from the treatment program.

Patient consent form

I,_____, have read (or have been read) the patient information sheet about methadone maintenance treatment. I have been offered the chance to ask questions about this treatment and am satisfied that I have the knowledge to make an informed decision about this treatment option.

I have been informed of the rules I must follow to continue receiving this treatment, and am aware of the penalties for breaking those rules.

I am aware that I can choose to cease this treatment at any time.

Signed:

Name:

Date:

Witness signature:

Name:

Date:

6.3 MANAGEMENT OF DOSING

Patients in methadone maintenance treatment must be dosed once every day. Methadone dosing must be strictly managed in order to minimise *diversion.* Diversion refers to patients giving or selling their methadone to others for other's use:

- A patient may deliberately not swallow, or swallow and then vomit, their dose in order to sell it or give it to another resident
- A patient may be forced by another resident to give their dose away

A well-managed program can minimise the risk of diversion by having clear dosing procedures, such as provided below, that are strictly followed.

Dosing procedure[18]

Dosing should be conducted by nurses or other health professionals under the supervision of nurses.

1. The patient (or a group of patients) is escorted to the medical clinic by a security officer. The security officer must ensure the patient:
    a. Has their sleeves rolled up
    b. Is not holding anything (other than an identification card, if required)
    c. Does not have any containers hidden in their clothing
    d. Has no absorbent material such as a sponge in their mouth

2. The nurse or other staff member conducting dosing must identify the patient. This can be done using a photograph attached to the patient's file, or an identification card held by the patient. It is crucial that the patient is correctly identified **each time** they are dosed.

3. Assess the patient for signs of intoxication:
    a. Watch for unsteady gait (e.g. stumbling while walking).
    b. Engage the patient in conversation to assess coherence of speech.
    c. Check for constricted pupils.
    d. If the patient is intoxicated, do not dose. Patients who present for dosing while intoxicated should be reviewed as soon as possible by the prescribing doctor and dosing nurses. Continued drug use despite being in treatment may be a sign that patient's methadone dose is inadequate for controlling their withdrawal symptoms. Therefore, the dose may need to be increased.

4. Check the patient's file for the size of their dose. Dispense the appropriate amount of methadone into a dosing cup. If desired, add water to the cup to dilute the methadone. Provide the cup to the patient and watch the patient consume the dose.

5. Ensure the patient places the dosing cup in a designated waste bin inside the clinic.
6. Ensure the patient has swallowed the dose. Ask the patient to drink a glass of water or speak.

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[18] Drug and Alcohol Methadone/Buprenorphine Treatment Procedures Index. Sydney, NSW Corrections Health Service, no date.

7. Record the dose provided in the patient's file.

8. Isolate patients receiving methadone in a post-dosing supervision room for 15-20 minutes. While in this room, patients should be supervised by security or healthcare workers. Staff should observe patients carefully to minimise the possibility of diversion.

Requests for dose increases

Patients who request a dose increase should be provided with their prescribed dose and referred to the prescribing doctor for review.

Dosing errors

Accidentally dispensing too much methadone to a patient can result in a life-threatening situation. It may be three to four hours after dosing before the patient shows signs of overdose. In case of overdose:

- Advise the patient of the mistake and the possible consequences (e.g. increased drowsiness, increased risk of respiratory depression).
- Observe the patient every fifteen minutes for fours hours and every thirty minutes for the next four hours. Each time, check the patient's breathing, circulation and level of sedation.
- Inform the clinic doctor of the mistake.
- If the patient loses consciousness, administer naloxone as a prolonged infusion and transfer the patient to hospital for further observation.

Missed doses

Patients are required to attend the clinic daily for dosing unless other special arrangements are made. However, patients may sometimes miss doses. They may choose not to attend for dosing, or may miss dosing through no fault of their own.

A suggested schedule for dosing patients who have missed doses is provided in Table 13. In all cases, staff should consult with patient as to why they did not present for dosing, as you may be able to assist the patient in resolving problems that have prevented them from attending the clinic.

Table 13: Dosing for patients who have missed doses

Consecutive missed doses	Action
1-2	Dose as normal
3-5	Highest of: Half normal dose OR 20mg. Gradually increase dose to previous level
5+	Reassessed by doctor before dosing

Vomited doses

Sometimes, patients may vomit their dose before it is absorbed into the body. Table 14 provides advice on re-dosing patients who have vomited. In all cases, consult with the patient to determine if they have been harassed or forced to vomit their dose to give to someone else.

Table 14: Dosing for patients who have vomited

Vomited dose	Action
Within 20 minutes, not witnessed by a staff member	Do not dose again
Within 20 minutes, witnessed by a staff member	Provide half normal dose if needed
After 20 minutes	No action necessary

Recording dispensed amounts

Medical clinics dispensing methadone should maintain clear records of the amount of methadone dispensed each day, and the amount of methadone stored on the premises. Records should also be kept of accidental spillage of methadone. Discrepancies between the actual amount of methadone on the premises and the amount recorded as being on the premises should be investigated by an independent staff member.

6.4 MONITORING MMT

Treatment review

At regular periods, the patient and prescribing doctor should meet for a treatment review. The following should be discussed at a treatment review:

- Suitability of the current methadone dose, withdrawal symptoms and side effects, requests for dose increases
- Other medications the patient is taking
- Physical and psychological health
- Current drug use, including signs of injecting drug use
- Review of treatment goals

At the commencement of MMT, treatment review should occur weekly. After two months in treatment, the frequency of treatment reviews can be reduced to once every four to six weeks.

Patients who are using illicit drugs, are suspected of diverting their methadone dose, or have recently had their dose increased or decreased should attend treatment review meetings weekly.

Urine drug screening

Analysis of a patient's urine for evidence of illicit drug use is expensive and will not stop patents from using other drugs. Furthermore, results can be unreliable. There is no evidence

that punishing patients for returning positive urine samples results in decreased illicit drug use. Urine drug screening should only be used for therapeutic purposes, for example, when a patient is suspected of using drugs and confirmation of this is required. This provides information that the doctor can use to identify if the patient's treatment needs are being met. For example, if a patient's urine sample shows continued heroin use despite being in MMT, it may be a sign that the patient needs a higher methadone dose.

Treatment duration

There is no set rule for how long someone should stay in methadone maintenance treatment. However, it is well known that the longer a patient remains in treatment, the better the outcome. Generally, patients should be encouraged to remain in methadone maintenance treatment for the length of their detention, and then provided with assistance to continue with treatment after release from detention.

Additional treatments

All patients should be encouraged to access additional treatments such as psychosocial interventions. However, they should not be mandatory. Counselling and similar treatments are more effective if they are entered into voluntarily.

Release planning for methadone patients

It is recommended that all patients receiving MMT in closed settings be assisted to transfer to a community-based MMT program to continue treatment. Remaining in MMT in the community will help the patient to avoid illicit drug use and HIV risk behaviours such as sharing syringes. It will also reduce the likelihood of drug overdose. Arrangements for transferring the patient's prescription should be made by the prescribing doctor several weeks before the patient is due for release, in order to allow time for the transfer request to be processed. It can be useful to employ a community liaison officer who can assist in arranging transfers between the closed setting and doctors in the local community.

Factors to consider when planning a patient's release include:

- Will the patient be living in an area with easy access to a methadone clinic?
- Will the patient be able to afford methadone treatment? Are government-subsidised treatment places available (e.g. for patients living with HIV)?
- What other support services can the patient access once released?

Case study: Release planning for prisoners in MMT in New South Wales, Australia.

Prisoners in New South Wales, Australia, can access methadone and buprenorphine maintenance treatment. Continuity of maintenance treatment between prison and community settings is critical to reducing the risk of relapse to drug use and criminal re-offending. To help patients access community methadone maintenance programs after their release from prison, Justice Health (the organisation providing MMT in prisons) collaborated with community Area Health Services to implement an "in-reach project".

The in-reach project employs community health workers to visit prisoners receiving maintenance treatment who are soon to be released. The health worker assists the patient to arrange to continue methadone treatment in the community. The health worker also identifies other needs of the prisoner, such as accommodation, education or health needs and refers the prisoner to appropriate services. The objectives of the in-reach project are to:

- Minimise drug-related morbidity and mortality in released prisoners
- Minimise the barriers to entering methadone or buprenorphine programs
- Establish links between health agencies to ensure continuity of treatment between prison and the community
- Link patients with other services required to address their individual needs

An external evaluation of this project found that over 90% of patients referred to community-based treatment presented to the arranged clinic within 48 hours of release from prison.

Withdrawal from methadone prior to leaving the closed setting is not recommended. However, under some circumstances, it may be necessary. The patient may not be able to transfer to a community-based program, or the patients may request dose reductions with the aim of ceasing MMT before he or she is released. Patients should be advised that ceasing MMT prior to release might increase their risk of relapse and drug overdose. If a patient insists on ceasing MMT before release, follow the guidelines set out in section 6.5 Ending treatment.

6.5 ENDING TREATMENT

Voluntary cessation of treatment

Patients who wish to stop MMT should see their prescribing doctor to discuss their treatment options. The doctor should establish why the patient wants to stop MMT. Reasons for wanting to stop MMT may include:

- Belief that methadone is not appropriate in their case
- Belief that they no longer need treatment
- To avoid problems associated with MMT e.g. side-effects, harassment from others to divert dose
- To be "drug-free" prior to release from the closed setting.

Each of these reasons is legitimate, but the doctor should ensure the patient is aware of the benefits of MMT and has made an informed decision to cease treatment. In particular, patients who wish to cease MMT just before release should be informed of the increased risk of relapse and drug overdose in the weeks following release from a closed setting.

If a patient chooses to discontinue treatment, their treatment plan should be revised so that they will start receiving lower doses of methadone over a period of time. The patient should be told that this will happen.

Recommended dose reduction schedule:

- Reduce by 10mg per week until a dose of 40mg per day is reached.
- From then, reduce by 5mg per week until a zero dose is reached.
- Dose reductions should occur once a week or less often.

This schedule is a recommendation only. Rates of dose reduction should be discussed with the patient. If the patient is experiencing withdrawal symptoms, it may be appropriate to maintain the patient on a reduced dose for several weeks before recommencing the reduction schedule. Patients should be provided with additional psychosocial support during the dose reduction period.

A patient may begin to reduce his or her dose and later decide that they would prefer to remain in MMT. There should be procedures in place for these patients, and recently discharged patients, to be re-admitted to MMT on request.

Involuntary cessation of treatment

In some situations, it may be necessary to discharge a patient from MMT for the safety of other patients and/or staff. This may be because of violence or verbal abuse towards other patients or staff, or repeated incidents of methadone diversion. Before deciding to remove a patient from MMT, consider that the patient:

- May become more difficult to manage if removed from the methadone program
- May recommence or increase illicit drug use

Patients who commit minor infractions, for example, illicit drug use or refusal to provide a urine sample, can be disciplined, but should not be made to stop MMT. Methadone doses should never be withheld as punishment to patients. Patients should only be involuntarily removed from the program if their behaviour threatens the health and safety of others.

Patients who are made to cease MMT should be placed on the same dose reduction schedule as described for patients voluntarily ceasing treatment. If the patient is considered a serious risk to the safety of staff or other patients, they can be given this reducing schedule of doses in an area away from the clinic, such as their living quarters.

Pregnant patients

Cessation of methadone maintenance treatment during pregnancy is not recommended. Pregnant women should be provided with information about the benefits and risks of methadone during pregnancy. If a woman chooses to stop methadone treatment during pregnancy, it is recommended that dose reductions begin during the second trimester. Dose decreases should be 2.5 to 5mg per week, and the patient should be closely monitored for signs of withdrawal.

WHO Western Pacific Region
PUBLICATION

ISBN-13 978 92 9061 430 2