

Comorbidity of substance abuse and mental disorders

May be known as 'dual diagnosis'

What is it?

Many prisoners have complex multiple disorders.¹ Polydrug users may be simultaneously dependent upon alcohol, benzodiazepines and opiates, with a history of self-harm and other more overt attempts at suicide.² Many of the prisoners using illegal substances also have a mental disorder — most commonly, depression, anxiety and/or personality disorder; less commonly, a psychotic disorder. It is not possible to place most patients into **either** substance misuse **or** mental disorder categories so it is essential to identify and treat both types of problem in their own right.

Effects

Having a diagnosis of both substance misuse and another mental disorder is associated with increased rates of homelessness, imprisonment, violent behaviour, suicide, premature death and an increased use of emergency psychiatric hospital admission and other services.

The information in this section is meant to be read in conjunction with the guidelines on specific mental and substance disorders.

For further information on substance misuse and detoxification, see the Department of Health Guidelines on *Clinical Management of Drug Misuse and Dependence* and Prison Service Order 3550: Clinical Services for Substance Misusers.

Different types of comorbidity

- **Primary mental disorder with subsequent/consequent substance misuse**, eg depression leading to the use of drugs to deal with anxiety and distress related to early childhood trauma.
- **Primary psychoactive substance use disorder leading to psychiatric symptoms**, eg prolonged use of amphetamines or cocaine causing psychotic symptoms.
- **Withdrawal from substances leading to psychiatric symptoms**, eg 'uppers' (amphetamines, cocaine, ecstasy) can cause acute depression when 'coming down'.
- **Concurrent diagnoses such as opiate dependence and major depression**. In this case, withdrawal from the substance can result in the need for active management of the depression.
- **Common aetiological underlying factors**, such as post-traumatic stress disorders (PTSDs) leading to both substance misuse and mood disorders.

Which disorders are associated with each other?

The strongest associations between disorders in a prison setting are the following.

- **Personality disorder** (especially antisocial personality disorder) and **drug dependence** (especially dependence on stimulants and opiates).
- **Depression and anxiety that underlie substance misuse** but are also significantly aggravated by it. Most people will show a marked improvement on completion of withdrawal, but a significant minority may experience severe anxiety or depressive disorder and should be assessed and managed for that condition.
- **Psychotic disorder and psycho-stimulant use**.

This section deals with comorbidity of substance misuse and mental disorders only. Other disorders commonly found together include transient psychotic disorder occurring when someone with a personality disorder is under stress. Information about managing someone with a severe personality disorder and mental disorder can be found at **Prisoners with complex presentations and very difficult behaviours** (page 202).

Presenting problems

- **Self-harm and suicide** during and after detoxification or withdrawal. This is a particular problem with psycho-stimulants, eg cocaine and amphetamines. Rates of use among those entering prison are high. Cocaine has a short half-life in the blood stream, does not have a specific medication for treatment and patients often fail to disclose their habit. Sleeplessness is a consequence of withdrawal from some substances (eg opiates, alcohol, hypnotics) and exacerbates the risk of self-harm, suicide and relapse. It is a particular problem in prisons.

- **Chaotic, high-risk taking and self-harming behaviour.** This is associated with polydrug use with mixtures of opiates, alcohol, psychostimulants and benzodiazepines. Self-harming behaviour is very common among women, but also occurs frequently among male prisoners.
- **Unpredictable, agitated, irritable/aggressive behaviour** may occur during and after withdrawal.
- **Primary sleep problems.**
- **Depressive symptoms.**
- **Symptoms of anxiety.**
- **Psychotic symptoms.**

Assessment

This is aimed at establishing:

- the chronology of the disorders
- the interrelationship (if any) of the disorders and
- whether the disorders need independent treatment or whether treating one will help alleviate the other.

It is not possible to tell in advance from the symptoms alone whether psychiatric symptoms are drug-induced or whether the patient has a mental disorder and is also abusing drugs.

History

To establish the above, take a history of the following:

- **Drug use:** type of drug(s), dose (weight, cost), how often, route of administration, effects, complications (physical, psychological, social), level of tolerance, withdrawal experience, dependence syndrome, history of drug use.
- **Recent history of alcohol use:** type and amount drunk where possible, effects, complications (physical, psychological, social) (see **Alcohol**, page 18).
- **Psychiatric history:** nature of illness, where treated and with what, any relationship with drugs or alcohol.
- **Mental State Examination (MSE):** more information is provided on the disk, including an MSE form that can be printed out .
- Corroborate information as much as possible (friends, relatives, other staff, old psychiatric reports, Drug Unit notes). Obtain a urine drug screen and liver function tests. Remember that use of drugs or alcohol may lead to blurring of historical events and facts, or a rationalisation to justify use.
- Where a patient has a previous diagnosis of psychotic illness, involve mental -health staff in the assessment and treatment (eg liaise with a mentally disordered offenders team or the equivalent). Confirm previous treatment if possible.
- When conducting the initial assessment, take care to distinguish between alcohol withdrawal and opiate withdrawal. Inappropriate use of opiates in alcohol withdrawal could result in death if the patient has no neuro-adaptation to opiates.
- Identify those patients with a history of delirium tremens or withdrawal seizures and ensure an appropriate active management. Be aware that the sensation of 'insects crawling under the skin', hallucinations and delusions are symptoms both of cocaine use and of delirium tremens in alcohol withdrawal. The patient may be unaware of the cause of the symptoms. Delirium tremens may be diagnosed by a history of alcohol use, the appearance of symptoms in the first 48–72 hours of withdrawal, the presence of the shakes and with tachycardia. Severe delirium tremens is an acute emergency. Transfer immediately to an NHS hospital to ensure safe management (for more information, see **Alcohol misuse** and **Drug misuse**, pages 18 and 55).

Assessment might require observation over an extended period. Careful recording of the time of resolution of symptoms following withdrawal will provide useful diagnostic clues. Periodic reassessment may be appropriate.

It is frequently not possible to establish which disorder is 'primary'.

Management

Key management principles

- Never assume that all mood and behavioural symptoms are solely caused by the substance abuse, even in the absence of a previous psychiatric diagnosis. It is important to identify and treat both types of disorder in their own right.

- Establish a provisional diagnosis but maintain an open mind and use on-going assessment to confirm the diagnosis.
- Attend to the substance-misuse problem if dependence is suspected and stabilise on a regimen, eg with opiate substitution therapy or benzodiazepine detoxification if appropriate.
- Reassess the individual in 1–2 weeks.
- If the psychiatric symptoms persist, initiate the appropriate treatment.
- Be aware that during and after detoxification is a time of high risk for self-harm and suicide. Supportive counselling is needed at this time, eg counselling, assessment, referral, advice and throughcare services (CARATS) staff, chaplains, befrienders, peer-support workers. Assessments from mental health-trained nurses or doctors should be available as required.
- Detoxification must be done under medical and nursing supervision.
- If management takes place under primary-care supervision, ensure that both psychiatric and substance misuse expertise/advice is available — ideally someone with expertise in both areas.

Advice and support to the patient and provision of physical care

- Advise patients that the use of alcohol or drugs exacerbates mental-health problems and in some cases causes them. Only by reducing or stopping alcohol or drug use will it be possible to assess the mental-health problem fully. It is important, however, to do this safely and to provide support for the patient during a time of increased emotional vulnerability.
- Assess and manage physical health problems (eg abscesses, thromboses, chest infections and other respiratory tract infections such as tuberculosis, subdural haematomas) and nutritional deficiencies (eg vitamin B₁).
- Offer hepatitis B vaccination to all injecting drug users and consider its use for non-injectors who are smoking heroin, polydrug using, or involved in other forms of risk behaviour. Rates of hepatitis C are estimated to be at least 50% among injecting drug users. An estimated 20% of hepatitis C-positive individuals develop chronic liver disease, including liver cancer.³

Monitoring for mental-health problems during and after detoxification

- Monitor for suicidal ideation (see **Suicide assessment and management**, page 204).
- Monitor for depression and anxiety (see **Depression and generalised anxiety disorder**, page 47 and 64). Where there is a well-substantiated history of prolonged and dependent use of benzodiazepines and they are being withdrawn, anxiety levels may increase to intolerable levels. Consider slowing down the detoxification programme and supporting the patient to learn alternative ways of managing anxiety, eg refer to mental-health services for anxiety management work.
- Monitor for psychotic symptoms. If psychotic phenomena emerge or get worse as detox progresses, check the patient's history of prescribed and non-prescribed drug and alcohol use. Worsening psychotic symptoms may be associated with:
 - withdrawal from major or minor tranquillisers. Consider gradual medicated withdrawal if appropriate and
 - alcoholic hallucinosis or previously unidentified Wernicke–Korsakoff syndrome. Wernicke's encephalopathy should be assumed where any one of ataxia, confusion, memory disturbance, hypothermia and hypotension, ophthalmoplegia or unconsciousness are present. Transfer immediately to a hospital where parenteral vitamin supplements may be safely administered.

Psychotic illness

If psychotic symptoms remain, involve the mental-health services. Anyone who has been in custody for a more than a few days without access to drugs and remains psychotic is likely to have a primary psychotic disorder. If self-harming behaviour emerges in the context of withdrawal, the patient's mood state should be assessed and support offered (see **Assessment and management following an act of self-harm**, page 211). There is a need for caution, however, to ensure that withdrawal regimens are not manipulated through self-harming behaviour. Hyperarousal associated with acute benzodiazepine withdrawal can significantly aggravate self-harming behaviour.

Personality disorder

Borderline personality disorder may be associated with disturbed behaviour during withdrawal, including dissociation and transient psychotic symptoms. It may also be associated with polydrug

misuse as well as polypharmacy. In this situation, gradual withdrawal may be preferable, together with efforts to rationalise polypharmacy and reduce the overall number of medications prescribed. There is a high prevalence of personality disorder among prisoners with alcohol and drug dependence. Practitioners should ensure that patients with personality disorder can access the same treatment as those without and are not disadvantaged because of negative predictions about their response to treatment. Those providing services require expertise in both substance misuse and mental disorders (see **Personality disorder**, page 70).

Medication

Where the patient has a history of seizures, be cautious when using medication that will lower seizure threshold, eg tricyclic anti-depressants (TCAs), phenothiazines. Benzodiazepines during the withdrawal period will help reduce the risk of seizures.

Patients should not be initiated on benzodiazepines except under exceptional crisis situations and only in the short term. Patients previously maintained in the community on benzodiazepines for anxiety-related indications, however, should not necessarily have this treatment withdrawn.

All types of psychotropic medication (and other medication, eg analgesics) may be used as currency in the prison. Non-pharmacological methods of managing anxiety, sleep problems and mild depression should be available. Appropriate pharmacotherapy for depression and anxiety should also be available to patients with a history of drug misuse, but caution should be exercised. Treatment should be monitored and reviewed regularly to assess progress, the suicide risk, the continuing need for medication and any problems with administering the medication.

Opiate maintenance programmes

Be aware that methadone levels can be raised by some antidepressants (fluvoxamine) and reduced by anticonvulsants, anti-tuberculous medication and combination therapy for HIV.

Depression

- The risk of suicide is particularly high in the period that follows starting antidepressants (as slowing of thought and movement may improve before mood lifts), so close monitoring will be required during this critical period. At first, the patient may only notice side-effects. Explain to them that these show the medication is beginning to work and that he/she will feel better soon.
- Be aware that the sedating effects of prescribed sedating antidepressants (eg amitriptyline, dothiepin, trazodone) will be enhanced by 'downers' such as opiates and benzodiazepines. There have been a number of deaths where methadone and TCA medication interactions have resulted in respiratory depressions. TCAs should be avoided in combination with methadone prescribing. Selective serotonin re-uptake inhibitors (SSRIs) and similar compounds are not devoid of interaction with other drugs, but have the advantage of being safer in overdose.
- If the patient misuses alcohol and is about to be released, SSRI antidepressants are preferred to TCAs because of the risk of tricyclic-alcohol interactions (fluoxetine, paroxetine and citalopram do not interact with alcohol) (see *BNF* Section 4.3.3).
- Avoid monoamine oxidase-inhibiting (MAOI) antidepressants. These can have potentially fatal interactions with 'uppers' (eg amphetamines, cocaine, ecstasy). Signs include high blood pressure, chest pain, neck stiffness, rigid muscles, flushing, vomiting and severe headache.

Psychosis

- **Antipsychotic medication makes seizures more likely during detoxification.** Confirm previous treatment if possible. Caution is required in the introduction or increase of anti-psychotic medication. Ensure an appropriate and active medication of withdrawal symptoms to reduce the risk.
- Be aware that the sedating effects of prescribed antipsychotics will be enhanced by 'downers' such as opiates and benzodiazepines. In mild cases, this will cause increased drowsiness, but in severe cases it may cause confusion, ataxia and reduced respiration.

Sleep problems

Profound sleep deprivation is a part of the experience of major drug withdrawal. Consider a **strictly short-term** use of a hypnotic in the very early stage of withdrawal. Explain the risk of developing dependence on these medications to the patient. For longer term or less severe insomnia, advise sleep hygiene rather than drugs (see the patient leaflet *Getting a Good Night's Sleep* on the disk).

Administering medication

Take steps (eg supervised consumption) to ensure that the patient is not persuaded/bullied into passing his/her prescribed medication on to others, thereby placing themselves at risk of withdrawal symptoms.

After detoxification and withdrawal

Where psychiatric symptoms remain after detoxification

- Make regular appointments to review mental state. This may be done by the Detoxification Unit, with input from the mental-health services, or by primary-care staff with input from the mental-health services.
- Depressive symptoms improve in over 80% of individuals after detoxification. If major symptoms persist after alcohol, stimulant or opiate withdrawal, assess and treat for depression (see **Depression**, page 47).
- **If anxiety and agitation remain or increase after detoxification:** check for a history of benzodiazepine dependence. If benzodiazepine dependence is established and a decision is made to prescribe a benzodiazepine, use a long-acting one (eg diazepam) and consider instituting a programme of gradual withdrawal. Such prescribing should be combined with anxiety management treatment.
- Assess and treat anxiety with appropriate non-pharmacological strategies (eg anxiety management) as a first-line intervention. Alcohol/substance use can also mask disorders such as panic disorder, social phobia and generalised anxiety disorder (see **Generalised anxiety, Panic and Phobias**, pages 64, 67 and 79).

If psychotic symptoms remain after detoxification

- Refer for psychiatric assessment (if possible to a psychiatrist with expertise in substance misuse and mental illness) and treat (see **Acute psychosis**, page 11).
- Observe closely while awaiting assessment or transport. Depression, with a high risk of suicide, is common in a patient with a psychotic illness during the weeks following withdrawal.
- Be aware that a psychotic illness may emerge for the first time or as a result of severe stress.
- Ensure that any antipsychotic medication prescribed is not causing unacceptable side-effects (eg akathisia).
- Be aware that the presence of complex problems with poor social support greatly reduces the chances of the patient successfully remaining drug free. Take all steps possible to maximise the chance of the individual staying in on-going treatment, both within the establishment and the community. In some instances, supervised maintenance treatment will help keep the patient in treatment after release.

Stimulants: where problems emerge on ordinary location

Cocaine withdrawal

There is no specific medication to treat cocaine withdrawal and prisoners often fail to disclose their use at reception. Withdrawal after heavy stimulant use over several days may produce a 'crash' that lasts hours or several days. Cocaine withdrawal begins with depression, agitation, anorexia and craving, during which time the suicide risk is high. This is followed by fatigue and insomnia accompanied by an intense desire to sleep. In the later stages of the crash, there is exhaustion and excessive sleeping. For several weeks afterwards, there may be variable craving, anxiety and other symptoms.⁴

Amphetamine withdrawal

This is longer but may be less severe than cocaine withdrawal. Prison officers may assume that prisoners who sleep excessively have taken an overdose as they may be unaware of the 'crash' that can occur following stimulant use. Officers need to be made aware of this issue so that they can bring those who seem to be showing stimulant withdrawal symptoms to the attention of the health-care and substance misuse staff.

Support for a prisoner withdrawing from stimulants

- Make basic observations (pulse, blood pressure [BP], temperature), which will usually distinguish between overdose or non-tolerance of methadone and heavy sleep. If the BP is very depressed, the patient extremely tachycardic or they are difficult to rouse, or there is any serious doubt about the level of intoxication, refer the patient to the local A&E for full assessment. A clear joint protocol on this process should be drawn up between the prison and the local NHS service and best practice

standards jointly agreed (see **Management of poisoning**, page 225). If the patient appears to be sleeping heavily, continue to monitor for 72 hours.

- Provide supportive treatment plus sedation if agitation and anxiety are severe.
- Monitor the course of withdrawal to prevent suicide.

Substance-induced psychosis has been associated with stimulant intoxication and may persist after drug use has been discontinued. Individuals who have psychotic symptoms and are still intoxicated because of stimulants should be managed in an in-patient setting. Antipsychotic medication may be helpful.

Liaison and advice for discipline and other staff

It is essential to provide information and advice for any officers or other staff who are involved in supervising individuals during and after they are going through a detoxification programme. Wing managers and personal officers may also be very helpful sources of information about the prisoner's behaviour on ordinary location.

Advice that can be given

- Strange and difficult behaviours in people who use illicit drugs are not always caused by the drug use or withdrawal. They must be treated seriously and reported.
- Individuals undergoing and just after withdrawal/detoxification are emotionally vulnerable and at a considerably increased risk of suicide and self-harm.
- Behaviour that can be expected from prisoners withdrawing from drugs includes:
 - a 'crash' into exhaustion/excessive sleep following stimulant use
 - irritable outbursts or aggression following the sudden cessation of treatment for depression or withdrawal from illicit drugs (eg opiates or steroids) and
 - the sensation of 'insects crawling under the skin', hallucinations and delusions: symptoms both of cocaine use and of delirium tremens in alcohol withdrawal. The individual may be unaware of the cause of the symptoms. Severe delirium tremens is an acute medical emergency.
- Methadone can be a legitimate, on-going treatment prescribed for good reasons rather than a mode of feeding a drug habit. Issuing and monitoring methadone needs to be undertaken by experienced staff. If this is not understood and accepted, the staff are likely to resent having to escort patients daily to a central location to receive their maintenance dose of methadone.

Action that may be taken

- Remove dangerous objects and consider the use of suicide-prevention procedures.
- Report the behaviour to health-care. A review of medication or the speed of detoxification may be indicated.
- Use control and restraint as a last, not first, resort where irritability and aggression occurs.
- Use 'talking down' skills.
- Consider delaying adjudications until the withdrawal is complete, so that any improved behaviour can be taken into account.

Referral and throughcare (resettlement)

Management within the establishment

This is multi-disciplinary and may involve CARATS staff, probation officers, chaplains, discipline officers and psychologists in addition to health-care staff.

Refer to the psychiatric services (with expertise in both mental illness and substance misuse) the following patients.

- Those with a psychotic illness and a substance misuse problem for an assessment, including a review of medication, and additional support including relapse-prevention strategies. Use of substances may be related to levels of anti-psychotic medication (eg under-medicated patients may use alcohol or other drugs to drown voices).
- Those in whom anxiety symptoms that emerge during or following detoxification are severe/unmanageable.
- Those with severe or persistent self-harm or severe eating disorders.

Rehabilitation programmes

Prisoners with a mental-health problem and who are taking prescribed anti-depressant or anti-anxiety medication should not be coerced into stopping their medication prematurely in order to access a prison-based rehabilitation programme or to be released on to a community programme. The patient's mental-health needs should be assessed by an appropriately trained clinician and the rehabilitation programme asked to accept the person while still on treatment. Those with ongoing major mental-health problems will require maintenance medication. Referrals should only be made to services that recognise the role of medication in the treatment of both addictive disorders and other mental disorders.⁵

Prerelease

Many patients will leave prison before a full treatment programme can be completed. Where feasible (and with patient agreement), refer them as soon as possible to the local drug-treatment services and/or local community mental-health team/primary care. CARATS workers may be able to assist with this. If either the psychiatric or substance misuse problem appears to predominate, refer initially to that service. Make the rationale clear in the letter/fax. If both types of disorder are of equal significance, then negotiate with both agencies about the preferred initial referral route. It may be that the patient will require support and input from both agencies. Some areas provide services jointly. Some voluntary organisations specialise in clients with multiple disorders, working in conjunction with statutory services, eg Revolving Doors, MACA (see **Managing the interface with the NHS and other agencies**, page 149).

Post-release

It is important to prevent the current high death rate due to opiate overdose on release. Prisoners may allow themselves a 'treat' following their period of abstinence in prison. Advise prisoners about to be released of: the risk of overdose due to loss of tolerance to opiates, safer ways of using drugs (eg smoking) and basic resuscitation procedures. A leaflet about the ways to minimise the risk and to handle overdose, should it occur, is useful. It is on the disk and could be adapted by individual establishments.

Developing services in your establishment

Many establishments (and NHS services) will not yet have organised their services in a way that facilitates the identification and treatment of comorbid mental disorders in inmates who abuse substances.

The key factors in developing such services are the following.

- **Monitoring of mental state and suicide risk** of patients during and after detoxification and appropriate follow-up. Where patients are reviewed in primary-care clinics, it would be valuable to have mental-health-trained nurses (preferably with both mental-health and substance-misuse expertise). It is particularly important to distinguish between delirium tremens, alcoholic hallucinosis, drug-induced psychosis and a psychotic illness.
- **Specialist help in a psychiatric hospital**, if necessary, for patients undergoing withdrawal and who are at risk of severe delirium tremens, Wernicke-Korsakoff's syndrome or who are thought to have an ongoing psychotic disorder (see **Managing the interface with the NHS and other agencies**, page 149).
- **Education for all staff** about the emotional state of inmates during and after detoxification, in particular the potential for strong, volatile emotions and the increased risk of suicide and self-harm. They should also learn that mental-health problems frequently go along with substance use.
- **Hepatitis B injection programme** for all injecting drug users.
- **Supervised opiate agonist maintenance programmes** or extra-gradual withdrawal programmes for those drug users with complex needs and a long history of opiate dependence.
- **Mental-health liaison nurse** who can liaise between the prison and the NHS mental-health and substance-abuse services to facilitate the appropriate aftercare.

More details about detoxification are provided in Prison Service Order 3550 and Department of Health Guidelines 1999 'Drug Misuse and Dependence: Guidelines on Clinical Management'.

Resources for patients and primary support groups

ADFAM National: 020 7928 8900 (helpline)

(For families and friends of drug users)

Al-Anon Family Groups UK and Eire: 020 7403 0888 (helpline: Monday–Friday, 10 am–10 pm); 0141 2217356

(Support for families and friends of alcoholics whether still drinking or not. Also, **Alateen**, for young people aged 12–20 affected by others' drinking)

Alcoholics Anonymous: 08457 697555 (24-hour helpline)

(Helpline refers to telephone support numbers and self-help groups across the UK for men and women trying to achieve and maintain sobriety)

CITA (Council for Involuntary Tranquilliser Addiction): 0151 949 0102 (Monday–Friday, 10 am–1 pm)

Cavendish House, Brighton Road, Waterloo, Liverpool
(Confidential advice and support)

Narcotics Anonymous: 020 7730 0009 (10 am–10 pm)

National Drugs Helpline: 0800 776600 (24-hour freephone)

(Confidential advice including information on local services)

Release Helpline: 020 7603 8654 (helpline: Monday–Friday, 6 pm–10 pm; Saturday and Sunday, 8 am–midnight; 020 7729 9904 (heroin advice line))

(Advice, support and information to drug users and their friends and families on all aspects of drug use and drug-related legal problems)

Resource leaflets:

Harm Minimization Advice

Understanding Dual Diagnosis. General information booklet available for £1.00 from: MIND, 13–19 Broadway, Stratford, London E15 4BQ. Tel: 020 8221 9666;

E-mail: publications@mind.org.uk; URL: <http://www.mind.org.uk>

Helping You Cope: A Guide to Starting and Stopping Tranquillisers and Sleeping Tablets. Available from: Mental Health Foundation, 20/21 Cornwall Terrace, London NW1 4QL. Tel: 020 7535 7400; URL: <http://www.mentalhealth.org.uk>. See the guideline for relevant disorders for organisations that deal with that problem

- 1 Farrell M, Howes S, Taylor C *et al.* Substance misuse and psychiatric comorbidity: an overview of the OPCS National Psychiatric Morbidity Survey. *Addictive Behaviours* 1998; 23: 909–918.
- 2 Jan Palmer, personal communication. Statistics collected at HMP Holloway from 1996 to 2000 showed that 45% of new receptions required detoxification, of whom 50% required alcohol detox in addition to opiate detox; a further proportion required benzodiazepine detox in addition to one or both of opiate and alcohol.
- 3 Crofts N, Stewart T, Hearne P *et al.* Spread of blood-borne viruses among Australian prison entrants. *British Medical Journal* 1995; 310: 285–288.
- 4 Gawin FH, Khalsa ME, Ellinwood E. Stimulants. In Glanter M, Kleber HD (eds), *Textbook of Substance Abuse Treatment*. Washington, DC: American Psychiatric Press, 1994, pp. 111–139.
- 5 Scott J, Gilvarry E, Farrell M. Managing anxiety and depression in alcohol and drug dependence. *Addictive Behaviours* 1998; 23: 919–931.

Management of prisoners with complex presentations and very difficult behaviours

Introduction

Some individuals in prison present both healthcare and discipline staff with particularly difficult challenges. Most of these individuals may have multiple diagnoses of personality disorder, substance misuse and often have mental illness. Self-harm is common. Many are accused of or sentenced for crimes of violence. Prisoners may have a history of poor compliance with treatment, not complying with agreed care plans, a reduced recognition of behavioural boundaries and poor cognitive skills. Some prisoners with personality disorder tend to divide carers into rival groups. Prison Service staff often feel that such individuals are in prison for lack of any better disposal by society and the courts.

Challenging individuals are more likely to be found in special accommodation or in segregation units. There may be confusion about when and in what context they should be accountable for their actions.

Management

- Where the individual has had previous contact with NHS psychiatric services, they should have a care plan and a crisis plan within their Care Programme Approach (CPA) documentation. Contact the CPA Coordinator in the NHS psychiatric service in the first instance. He/she should liaise between the prison and NHS healthcare services.
- Regular multidisciplinary assessments of the health and management of prisoners are essential, with contributions from the wing staff, governor, probation officer, psychologist, nurses, psychiatrist and chaplain. Where the Board of Visitors has been involved in the particulars of an individual prisoner, it should be included in the case conference.
- The assessment should include both subjective and objective measures of symptoms and behaviours, identify any mental disorder and personality disorder, assess the risk and seek to explain the relationship between the disorders and problems in behaviour and management being experienced in the social setting of prison and other possible locations for the prisoner.
- Effective coordination of care is essential. Many of these patients need enhanced care plans as set out in the National Service Framework for Mental Health and protocols of the local mental health Trust. Care plans should be developed covering each of the problem behaviours. Care plans should be:
 - realistic: it should either be possible to put them into action within the prison, or include a planned transfer to hospital
 - multidisciplinary: the NHS multidisciplinary team should be asked for its advice/active involvement; staff from other relevant areas in the prison, eg psychologist, probation officer, chaplain and staff from Residential Units, should be involved
 - humane: responses to presenting problems should be non-punitive; attention should be paid to the dangers of protracted isolation (see **Isolation and mental health**, page 308)
 - evidence-based, wherever possible
 - flexible: it should be possible to respond to changes in the individual such as deterioration or improvement in mental state and
 - regularly reviewed: behaviour can change over time and care plans must be adapted. It is important to keep an open mind. The NHS staff involved in the assessment should be involved in reviews at agreed intervals.
- The location of these patients within a prison needs discussion. The benefits of concentrating or diffusing these individuals, and the risk of disruption to other prisoners, should be assessed. If available, consider transfer to an establishment where there is expertise in managing similar problems, where non-punitive responses like solitary confinement or isolation are unnecessary and where the environment allows the individual to socialise with others and to develop personally.
- When a team becomes divided or tired, an outside second opinion is often helpful.
- On-going and post-incident support for staff is essential. For example, consideration should be given to helping staff to become aware of, review and, if appropriate, develop additional coping mechanisms.
- Non-judgmental critical incident debriefing is useful. It may identify assumptions or management arrangements that are hindering management of individuals. Colleagues from within the NHS and prison management should be involved in these. An outsider can often identify a pattern that has not been seen by those closely involved.