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CONSENSUS STATEMENT OPEN ACCESS

The Management of Withdrawal From Alcohol and Other Drugs in Australian Custodial Settings: A Consensus Statement

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ABSTRACT

Introduction: For many people entering custody, abrupt changes in alcohol or other drug use is associated with the risk of experiencing a withdrawal syndrome. Management of withdrawal from alcohol and other drugs in a custodial setting is complicated by both a limited evidence base and structural barriers to the delivery of best practice healthcare interventions to people in custody.

Main Recommendations: A multidisciplinary expert panel representing all Australian states and territories participated in a modified Delphi process. The process generated 22 recommendations to custodial services, health services and government for the management of withdrawal from alcohol and other drugs in custodial settings across five domains: screening for withdrawal risk; assessment of withdrawal; management of withdrawal; specific considerations for the care of First Nations people; and organisational support. Notable recommendations include using universal and timely assessment for withdrawal at reception to custody; using validated clinical tools and evidence-based interventions to assess and manage withdrawal syndromes; and ensuring that the safest location for withdrawal from alcohol or other drugs is provided.

Changes in Management as a Result of the Statement: This statement presents best practice standards for the management of withdrawal from alcohol and other drugs in Australian custodial settings, as informed by evidence and expert consensus. Implementing the recommendations set out in this statement will improve the quality and consistency of withdrawal care provided to people entering Australian custodial settings and reduce harms associated with incarceration for people who use alcohol and other drugs. This statement has been endorsed by the Royal Australasian College of Physicians, the Australasian Professional Society on Alcohol and Other Drugs, the National Prisons Hepatitis Network, the Pharmaceutical Society of Australia and the Australian Injecting and Illicit Drug Users League. The statement is also approved as an Accepted Clinical Resource by the Royal Australian College of General Practitioners.

JEL Classification: Health services administration, Mental disorders, Social determinants of health

1 | Background

Many people entering Australia's custodial system have recent histories of substance use and will be at high risk of experiencing alcohol or other drug withdrawal syndromes [1, 2]. In 2022, 73% of people entering Australian prisons reported having used drugs in the previous 12 months [1]. For many people who use alcohol and other drugs, incarceration necessitates a significant change in patterns of substance use, including periods of forced abstinence or more irregular use.

Withdrawal is a syndrome that arises following cessation or reduction in use of a substance by an individual who has maintained prolonged or significant recent use of a substance. Withdrawal syndromes cause clinically significant distress and impairment and can be fatal [3]. Presenting features of withdrawal syndromes vary according to the substance, and careful assessment can be required to ensure the signs and symptoms of withdrawal syndromes are not attributable to medical or psychiatric illness [4]. In the community, an individual may choose to undergo supported withdrawal in order to make a change to their substance use [5]. In contrast, the typically involuntary nature of alcohol or other drug withdrawal when entering custody can heighten the challenges and risks [6].

Withdrawal is recognised as a major health issue affecting people in custody in Australia, but there are few published data regarding the incidence or consequences of withdrawal from alcohol and other drugs in Australian custodial settings [3]. There is scant evidence from Australian randomised controlled trials to inform the delivery of withdrawal interventions for First Nations people, culturally and linguistically diverse people, and people in custody [4]. 'Citizens' juries' of incarcerated people have identified that support relating to alcohol and other drug use, including withdrawal management, is a priority for research to improve the health of incarcerated populations [7].

Australia lacks national guidelines to instruct the management of withdrawal from alcohol and other drugs in custodial settings, in contrast to the United States and the United Kingdom [8, 9]. Consequently, alcohol and other drug withdrawal is currently managed inconsistently across custodial settings.

The National Prison Addiction Medicine Network (NPAMN) was convened in 2023 to address a gap in the national policy landscape relating to the provision of evidence-based best practice medical care for incarcerated people with substance dependence [10]. The network comprises clinical, consumer and public health experts from all Australian jurisdictions with relevant experience in providing and/or researching addiction and broader health services for incarcerated people.

This NPAMN consensus statement aims to improve the quality and consistency of care for people who are incarcerated in Australia by promoting an evidence-based approach to the management of withdrawal in custodial settings, including adult and juvenile prisons, remand centres and police cells. This statement is predicated on the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), which stipulate that people who are incarcerated are entitled to medical care that is equivalent to what they could access in the community [11]. The specific objectives of this consensus statement are to:

- present an overview of the evidence regarding best practice management of alcohol and other drug withdrawal in custodial settings; and
- provide expert consensus recommendations regarding best practice management of alcohol and other drug withdrawal in custodial settings.

2 | Method

2.1 | Expert Panel and Scope

Clinicians with experience providing alcohol and other drugs care in a Victorian prison defined the scope of the consensus statement, identifying five domains of clinical and health-system relevance. These were:

- the screening for risk of withdrawal from alcohol or other drugs at reception to custodial settings;
- the assessment of risk of withdrawal from alcohol or other drugs at reception to custodial settings;
- the management of withdrawal from alcohol or other drugs in custodial settings;
- the care of First Nations people at risk of withdrawal in custodial settings; and
- organisational support to improve the quality and consistency of withdrawal care for people who are incarcerated.

An initial steering panel (TN, GF, JCh, RW, SN, MC, MS, JC) was composed of NPAMN members who expressed interest in contributing to the drafting of the consensus statement. Other NPAMN members were then invited via email to participate in the online expert panel. NPAMN members who were unable to participate in the earlier online survey were nonetheless invited to participate in the later survey. As represented in Table 1, there were thus 25 expert panel participants with clinical, advocacy and public health backgrounds, with panel members from each of the Australian states and territories.

2.2 | Literature Review

GF used PubMed to search for peer-reviewed literature pertaining to the management of alcohol and other drug withdrawal in custodial settings. Key search terms were 'substance withdrawal syndrome', 'prisoners', 'correctional facilities' and terms relating to high-prevalence substances among people entering custody in Australia (alcohol, cannabis, amphetamine-type stimulants, opioids, nicotine) [12]. The term 'gamma-hydroxybutyrate' was added given the clinical importance of this substance in terms of withdrawal syndrome. The search strategy is included in the Supporting Information. Existing Australian and international withdrawal guidelines, peer-reviewed statements, grey literature and additional papers provided by members of the NPAMN

TABLE 1 | Composition of expert panel and degree of engagement ($N = 25$).

Characteristic	Number (%) of participants
Gender	
Male	15 (60%)
Female	10 (40%)
Primary field of employment	
Advocacy	1 (4%)
Healthcare administration	1 (4%)
Healthcare provider	18 (72%)
Research	5 (20%)
Geographical representation with regards to state/territory of origin	
Australian Capital Territory	1 (4%)
New South Wales	5 (20%)
Northern Territory	1 (4%)
Queensland	2 (8%)
South Australia	3 (12%)
Tasmania	1 (4%)
Victoria	9 (36%)
Western Australia	3 (12%)
Delphi process engagement	
Online meeting 1	16 (64%)
Online meeting 2	22 (88%)
Survey 1	19 (76%)
Survey 2	24 (96%)

networks were reviewed. Reference lists of each resource were searched. Where available, evidence identified in this review is presented as supporting literature.

2.3 | Modified Delphi Method

A modified Delphi method was devised that replicated the process used in an earlier NPAMN consensus statement [13, 14]. This method was selected to generate expert-guided recommendations given the limited evidence available to inform clinical practice in custodial settings. The steering committee drew on the literature identified at the review stage to develop a draft set of recommendations. These draft recommendations with their accompanying summary of the literature were disseminated to the expert panel following discussion at the May 2025 online meeting of the NPAMN (online meeting 2). The expert panel provided input on draft recommendations via the first round of anonymous survey (survey 1, completed by 19 members of the expert panel between 30 June and 21 July 2025), which was developed and distributed using the Qualtrics XM platform. This survey had been piloted by the steering committee before circulation to the expert panel. In this first survey, expert panel members were asked to 'agree' or 'disagree' with recommendations and were invited to provide comments for each recommendation using free text. The level of agreement for these initial recommendations is included in Table S1. None of the initial recommendations were removed. GF synthesised the feedback from survey 1 and disseminated a revised set of recommendations for immediate review by the steering committee. The second round of anonymous survey (survey 2, completed by all 25 members of the expert panel between 20 August and 3 September 2025) sought to confirm endorsement of the finalised recommendations. Expert panel members were asked to simply 'agree' or 'disagree' with recommendations. Steering committee members were also allowed to participate in both rounds of the survey. In each round of the survey, consensus with regards to the proposed recommendations was defined a priori as greater than 80% agreement from respondents [13]. Recommendations were categorised based on the level of agreement of survey responses, where 'U' denotes unanimous (100%) agreement, 'A' indicates 90%–99% agreement and 'B' means 80%–89% agreement. Grading of Recommendations, Assessment, Development and Evaluation was not undertaken given the limited evidence available to inform this consensus statement. The Delphi process was not prospectively registered. The study is reported following the methods outlined in the ACcurate COnsensus Reporting Document, a reporting guideline for consensus methods in biomedicine (see Supporting Information) [15]. This statement has been endorsed by the organisations listed in the Supporting Information.

3 | Results

The Delphi process yielded an initial 22 recommendations across five domains relating to the management of withdrawal from alcohol and other drugs in custodial settings. In the first survey, consensus was achieved for all of the recommendations—14 recommendations achieved unanimous agreement, six recommendations reached 90%–99% agreement and two recommendations reached 80%–89% agreement (Table S2). The recommendations and results of the second survey are detailed in Table 2. In the second survey, 14 recommendations achieved unanimous agreement and eight recommendations reached 90%–99% agreement.

3.1 | Consensus Recommendations and Supporting Literature

The consensus recommendations are contained in Table 2. Literature that informed the recommendations follows.

3.1.1 | Screening for Risk of Withdrawal From Alcohol or Other Drugs at Reception to Custodial Settings (R1.1–R1.3)

The Nelson Mandela Rules state that prompt medical assessment on admission to a custodial setting should include the identification of the risk of withdrawal symptoms resulting from

TABLE 2 | Consensus recommendations for management of withdrawal from alcohol and other drugs in custodial settings.

Domain	Consensus recommendations	Level of agreement[a]
1	**Screening for risk of withdrawal from alcohol or other drugs at reception to custodial settings**	
1.1	All individuals should be confidentially screened for risk of alcohol or other drug withdrawal using validated assessment tools within 24 h of their reception into custody	U
1.2	For people identified to be at risk of withdrawal, assessment of associated risks should include a substance use history, clinical examination, collateral history and investigations where these are indicated	U
1.3	Assessment for risk of withdrawal from alcohol or other drugs should occur in the context of a broader health assessment for all people entering custody. Comprehensive health assessments, including screening for harms associated with alcohol and other drug use, should involve serial reviews by multidisciplinary clinicians in the weeks after entrance to custody	U
2	**Assessment of risks associated with withdrawal from alcohol or other drugs at reception to custodial settings**	
2.1	Healthcare staff should assess for immediate withdrawal-related clinical needs at the time of reception to police cells and prison, and manage these appropriately	U
2.2	A clinically appropriate setting for withdrawal from alcohol or other drugs should be provided, based on an assessment of an individual's substance use history, their comorbidities, their history of previous withdrawal severity and any medical or psychiatric complications. For some people, this would involve transfer to an inpatient hospital setting	U
2.3	There should be established local protocols to identify those people whose withdrawal-related care needs to be managed at a hospital	U
2.4	Hospital transfer must be arranged if withdrawal-related or other healthcare needs cannot be met within the custodial setting	U
2.5	Individuals who, before entrance to custody, receive regularly prescribed medications associated with physiological dependence (including opioids and benzodiazepines) require medical review and assessment regarding the ongoing prescribing of these medications within the first 24 h of reception	A
2.6	Custodial health staff must request specialist addiction medicine and obstetric advice when managing a withdrawal syndrome in a pregnant person who uses alcohol or other drugs	A
3	**Management of withdrawal from alcohol or other drugs in custodial settings**	
3.1	No person should undergo acute untreated substance withdrawal. All people entering custody should be offered clinically indicated withdrawal management	U
3.2	Medical decisions related to withdrawal care should be independent of the custodial status of the patient—such as whether an individual is remanded, soon to be released or in a high-security environment	A
3.3	Local protocols should be available for the management of frequently encountered withdrawal syndromes in Australian prisons—for example, for the management of nicotine, alcohol, cannabis, methamphetamine, opioid, gamma-hydroxybutyrate and benzodiazepine withdrawal, and for the safe weaning of prescription medications that may not be available in the custodial setting	A
3.4	The frequency of clinical assessments should be based on patient circumstance, and best practice, with a minimum frequency described in local protocols	U
3.5	Assessment of withdrawal severity should be performed by appropriately trained staff and use validated clinical tools as outlined in Table 3 of this statement	A

(Continues)

TABLE 2 | (Continued)

Domain	Consensus recommendations	Level of agreement[a]
3.6	Thiamine supplementation should be provided when clinically indicated for prophylaxis against Wernicke encephalopathy, including as a parenteral preparation when indicated	U
3.7	In addition to any pharmacological treatments instigated for withdrawal management, acute withdrawal support should include consideration to provision of a low stimulus environment, access to cultural or linguistic supports where appropriate, peer support, psychoeducation and psychological support if clinically indicated	A
3.8	Withdrawal management should include consideration of post-withdrawal care. All people in custody should have access to ongoing treatment for substance use disorders if indicated during incarceration, along with linkage to harm reduction support both during custody and after release	U
4	**Care of First Nations people at risk of withdrawal from alcohol and other drugs**	
4.1	Custodial health services should collaborate with local Aboriginal community-controlled health organisations on culturally appropriate prison-health models of care where feasible	A
5	**Organisational support**	
5.1	All custodial and healthcare staff in custodial settings should be provided with a minimum level of training regarding: • psychoactive effects of common drugs including alcohol, of current and emerging trends in drug and alcohol use and harms and of the risks from prescribed drugs • screening for risk of withdrawal and other harms associated with alcohol and other drug use • recognising clinical deterioration, and seeking medical assistance when an individual demonstrates potential signs and symptoms of withdrawal or when an individual reports experiencing withdrawal	U
5.2	State and territory governments should monitor key indicators relating to the safe management of alcohol and other drug withdrawal, including screening, uptake, wait times and adverse events, to inform ongoing quality improvement	A
5.3	Custodial health services should develop relationships with local health services and public health units to improve the provision of care for people who use alcohol and other drugs	U
5.4	Custodial services should support people in custody to participate in research that will build an evidence base for improving health and wellbeing in this setting	U

[a]Grading of consensus responses: 'U' denotes unanimous (100%) agreement, 'A' indicates 90%–99% agreement and 'B' means 80%–89% agreement.

the use of drugs, medication or alcohol [11]. Both the UK and US guidelines for the management of alcohol or other drug withdrawal in custodial settings recommend routine screening for risk of withdrawal at the beginning of a period of incarceration [9, 16]. The 2018 Guiding Principles for Corrections in Australia describe identification and access to treatment, education and interventions to help minimise harm arising from alcohol and other drug use as an intended outcome of correctional interventions, but make no explicit reference to screening for risk of withdrawal [17].

Withdrawal from most commonly encountered substances occurs within 24–48 h of the most recent use; thus, screening for risks of withdrawal from alcohol and other drugs should take place within 24 h of reception into custody, or earlier should a person report or be observed to experience symptoms of withdrawal [5].

The World Health Organisation Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is an eight-item screening tool used to assess patients for moderate- or high-risk substance use that may require treatment. It has been validated for use in prisons and may assist in identifying individuals at high risk of hospitalisation after release from prison [18, 19]. The ASSIST tool does not refer directly to an individual's risk of withdrawal from alcohol or other drugs, but it may alert clinicians to the need for additional substance-specific assessments for withdrawal risk in a given individual.

Substances to consider on initial screening include nicotine (cigarettes, vaping products, chewing tobacco), alcohol, cannabis, amphetamine-type substances, cocaine, heroin, prescription opioids, gamma-hydroxybutyrate (GHB), benzodiazepines and z-drugs, gabapentinoids, antipsychotics, ketamine, hallucinogens and volatile inhalants including nitrous oxide and petrol [20]. In the absence of a tool such as the ASSIST tool, important components of a substance use history include frequency of substance use, methods of ingestion, experience of harms, previous attempts to change substance use and previous experiences of withdrawal syndromes [5, 20].

3.1.2 | Assessment of Risk of Withdrawal From Alcohol or Other Drugs at Reception to Custodial Settings (R2.1–R2.6)

Both UK and US guidelines stress the importance of risk assessment and management with regard to the physical and mental health risks associated with withdrawal syndromes [9, 16]. Beyond the initial screening for risk, both guidelines stipulate that healthcare services must plan for monitoring of any emerging withdrawal phenomena and plan to re-assess risks that might arise as a given withdrawal syndrome evolves [9, 16].

Medical assessment of individuals at risk of withdrawal should include a general physical and mental state examination to ensure that there are not underlying or concurrent medical, surgical or psychiatric conditions causing physical signs and symptoms attributed to substance withdrawal [20]. Clinical examination should endeavour to identify psychosis or other phenomena that might compromise an individual's decision-making capacity or present a risk of harm to them and others [20]. Physical examination should include assessment for malnutrition, injecting-related harms, organ damage related to substance use, pregnancy and injury [20]. Further investigations might be considered to detect organ damage related to substance use, injecting-related harms, sexually transmitted infections and unplanned pregnancy [20]. Biochemical investigations should be considered to inform appropriate pharmacological therapy for a given withdrawal syndrome [20].

The safety of an individual undergoing withdrawal should determine the appropriate withdrawal setting [5, 20, 21]. Hospital-based withdrawal is generally indicated for those with a history of severe withdrawal (e.g., withdrawal seizures, psychosis, delirium, or cardiovascular complications such as severe hypertension, arrhythmias), individuals withdrawing from multiple substances concurrently and individuals who have a medical comorbidity (e.g., severe cardiovascular or respiratory disease, or systemic infection) or psychiatric comorbidity (including suicidal ideation or psychosis) [5, 22].

Structural barriers to provision of medical care must be incorporated into an assessment of risk relating to withdrawal from alcohol and other drugs. Police cells and prison settings are not resourced to provide acute medical care for unwell individuals. At times, custodial services will also prioritise custodial processes and operations above consideration of medical care [23, 24]. Victorian prison-based withdrawal guidelines identify environmental factors, including limitations placed on the movement of an individual within the prison, workforce limitations and service disruptions associated with prison lockdowns as factors that might necessitate transition of care for a given individual to a hospital setting [25].

Individuals experiencing incarceration are at higher risk of unplanned pregnancy, inadequate prenatal care and poorer pregnancy outcomes than the general population [26]. Contributing factors include substance use, poverty and limited access to antenatal care [27]. Australian observations illustrate a significant discrepancy between substance use histories reported by pregnant people at initial health screening upon prison entry and subsequent reports to specialist drug and alcohol clinicians up to 2 weeks later [28]. People who are pregnant are thus at risk of delays in the provision of timely withdrawal management or receipt of evidence-based perinatal care, such as opioid agonist treatment induction, where appropriate [13, 28]. All pregnant people who use alcohol or other drugs should have the opportunity to receive specialist support, as even low-level or infrequent substance use that does not meet the threshold of problematic use may have consequences on an infant's health and development and obstetric risks [21].

3.1.3 | Management of Withdrawal From Alcohol or Other Drugs in Custodial Settings (R3.1–R3.8)

There is little evidence to inform best practice management of alcohol and other drug withdrawal in custodial settings [4]. The risk of potentially life-threatening withdrawal syndromes—including those from alcohol, opioids and GHB—must be considered where use of these substances is reported [4]. Clinical staff should be trained in the use of validated tools for identification of severe withdrawal from a given substance. Validated tools used to monitor alcohol and other drug withdrawal in Australia are outlined in Table 3.

3.1.3.1 | Management of Specific Substance Withdrawal Syndromes

3.1.3.1.1 | Alcohol. Underdiagnosed or poorly managed alcohol withdrawal can progress to life-threatening conditions, including alcohol withdrawal seizures and alcohol withdrawal delirium. Repeated alcohol withdrawal episodes exacerbate the severity of withdrawal symptoms and can contribute to long-term cognitive impairment [39]. Current prison-based withdrawal protocols recommend that hospital transfer be considered for individuals with a history of alcohol-withdrawal seizures or agitated deliriums [40, 41]. South Australian and Victorian procedures for managing alcohol withdrawal in custodial settings recommend fixed-dose benzodiazepine management where feasible [25, 41]. Wernicke encephalopathy is a severe and preventable comorbidity of alcohol withdrawal [42]. South Australian, Victorian and New South Wales procedures for managing alcohol withdrawal in custodial settings recommend prophylactic thiamine [25, 40, 41].

3.1.3.1.2 | Cannabis. No current pharmacological treatments are approved for the treatment of cannabis withdrawal [43]. Australian guidelines support the use of benzodiazepines, pain relief and antiemetics to address the symptoms of cannabis withdrawal [5, 25].

3.1.3.1.3 | Opioids. Acute opioid withdrawal, if severe, can lead to fatal electrolyte imbalances and cardiac arrhythmia [44]. Buprenorphine and methadone are effective medications for managing acute opioid withdrawal syndromes [45]. The NPAMN-authored *National consensus statement on opioid agonist treatment in custodial settings* recommends that custodial services assess and offer treatment to people at risk

TABLE 3 | Clinical tools used in the assessment of withdrawal from alcohol or other drugs.

Withdrawal assessment tool	Withdrawal syndrome	Comments
Clinical Institute Withdrawal Assessment—Alcohol (revised)	Alcohol withdrawal	Widely used in international settings; easy to administer and score [29, 30]
Alcohol Withdrawal Scale	Alcohol withdrawal	Validation of the Alcohol Withdrawal Scale has not been published, yet it is widely used and is considered acceptable for use in the current *Guidelines for the treatment of alcohol problems* [31]
Clinical Opiate Withdrawal Scale	Opioid withdrawal	Measures both objective and subjective indicators of withdrawal [32]
Amphetamine Cessation Symptom Assessment	Amphetamine withdrawal	Validated with an Australian population [33]
Amphetamine Withdrawal Questionnaire	Amphetamine withdrawal	Short questionnaire; unclear validity when used with women [34, 35]
Cannabis Withdrawal Scale	Cannabis withdrawal	Validated with an Australian population of males and females [36]
Clinical Institute Withdrawal Assessment—Benzodiazepine	Benzodiazepine withdrawal	Limited evidence regarding applicability in the Australian context [37, 38]

of opioid withdrawal within 24 h of reception into custody and that people at risk of opioid withdrawal should be monitored by appropriately qualified healthcare providers for at least 72 h following detention [13]. Individuals experiencing opioid withdrawal should be screened for an opioid use disorder and, where appropriate, offered opioid agonist treatment [13].

3.1.3.1.4 | Amphetamine-Type Stimulants. There are no evidence-based pharmaceutical treatments for amphetamine or methamphetamine withdrawal, and current clinical practice is psychoeducational with the provision of medications for symptom relief [4]. Australian guidelines support the short-term use of benzodiazepines or antipsychotics to manage agitation and anxiety associated with stimulant withdrawal [5, 25].

3.1.3.1.5 | Gamma-Hydroxybutyrate. GHB withdrawal can lead to delirium, seizures and rhabdomyolysis [46]. While there is limited evidence to inform optimal management of GHB withdrawal, there should be a clear threshold defining when a person requires hospital-based assessment and treatment for GHB withdrawal [4]. Most Australian clinical practice for the management of GHB withdrawal involves the use of high-dose benzodiazepines, which requires close clinical supervision [5]. Current Victorian and South Australian prison-based withdrawal procedures recommend that hospital transfer be considered for individuals using over 30 mL of GHB per 24 h before their incarceration [25, 41].

3.1.3.1.6 | Nicotine. People in custody are at high risk of harm from tobacco use and are a population with a high prevalence of pre-incarceration tobacco use [47]. Evidence-based interventions for smoking cessation that are effective in the general community are also effective inside prisons, with effects that persist after release [48]. In the absence of adjunctive treatments, smoking bans (which currently exist in most Australian prisons) are not associated with smoking cessation after release [48, 49]. The absence of access to evidence-based smoking cessation medications in custodial settings is thus in violation of the Nelson Mandela Rules. The National Tobacco Strategy 2023–2030 and the Royal Australian College of General Practitioners recommend that governments enhance evidence-based tobacco cessation support for prisoners, including access to nicotine replacement therapies [47, 50].

3.1.3.2 | Other Considerations. There is little evidence to inform the management of withdrawal from prescription medications that may not be available in custodial settings, including gabapentinoids and antipsychotics. Standard of care outside a prison is gradual tapering of these medications [51].

During an acute withdrawal period (the duration of which will depend on the substances implicated), reasonable frequency of clinical assessment depends in part on the anticipated severity of the particular withdrawal syndrome [5]. For lower-risk withdrawal syndromes such as those for cannabis and methamphetamine withdrawal, initial withdrawal assessment frequency might be twice per 24-h period for an initial 72 h [5, 25]. For higher-risk withdrawal syndromes, such as those for alcohol, opioid or GHB withdrawal, assessment frequency may be as high as 2-hourly, or four times per 24-h period for an initial 72 h [5, 25].

Effective withdrawal management involves a combination of psychosocial, physical and pharmacological interventions [5]. Acute withdrawal support should include consideration of care in a low-stimulus environment, access to cultural or linguistic supports where appropriate and provision of psychoeducation and reassurance [5].

Acute withdrawal care should be integrated into a broader care plan that addresses the individual's substance use, health

and wellbeing [22]. Structured linkages to post-withdrawal treatment are associated with greater engagement with post-withdrawal treatment for substance use disorder [22].

3.1.4 | The Care of First Nations People at Risk of Withdrawal in Custodial Settings (R4.1)

The overincarceration of First Nations people in Australia necessitates careful attention to the health and wellbeing needs of this community [1]. Approaches to reducing alcohol and other drug-related harms among First Nations people must be culturally safe and trauma informed in recognition of the impacts of colonisation on First Nations substance use and overincarceration [52]. Tobacco, cannabis and alcohol are the substances most commonly used by First Nations peoples who are incarcerated in NSW, with most of these individuals using more than one substance [53]. There are striking differences in patterns of substance-related mortality for First Nations people in Australia following release from prisons, which highlights the importance of tailoring interventions to reduce harms related to alcohol and other drug use to individuals and their communities [54]. Consistent with recommendations from the 1991 Royal Commission into Aboriginal Deaths in Custody, peer-reviewed analyses and coronial inquests continue to recommend a prison-based model of care that integrates Aboriginal community-controlled health organisations in order to effectively support First Nations people experiencing incarceration [3, 55–57].

3.1.5 | Organisational Support (R5.1–R5.4)

UK guidelines stipulate that the management of withdrawal syndromes in custodial settings should be delivered by professionals who are suitably competent, properly supervised and operating within a clear quality and clinical governance framework that support safe and effective delivery [9]. Custodial staff should be broadly aware of major psychoactive drug types, including risks relating to the use of prescribed substances or polypharmacy [9]. Clinicians should be able to estimate and manage risks relating to inadequately addressed intoxication or withdrawal, medical or psychiatric comorbidities and delayed recognition and management of high-risk withdrawal syndromes [9].

The National Safety and Quality Health Service Standards and the Royal Australian College of General Practitioners *Standards for health services in Australian prisons* outline setting-specific indicators that might demonstrate how the health service provides quality, safe and effective care for people in prison [58, 59].

The scant literature available to inform best practice withdrawal management in custodial settings is reflective of large gaps in the evidence regarding healthcare interventions for people in custody [60]. The right of a person in prison to receive community-equivalent health care likely extends to a right of community-equivalent access to research participation. Where there is rigorous ethical oversight, custodial services should support incarcerated people to participate in research that is relevant and potentially beneficial to the wellbeing of people in custody [61].

4 | Conclusion

This consensus statement promotes a nationally coordinated and evidence-based approach to the management of withdrawal from alcohol and other drugs in prisons, police cells and juvenile detention centres in Australia. Review of available literature demonstrates a paucity of evidence available to guide best care in custodial settings. In line with the principle of equivalence of care, we draw on evidence-based guidelines for individuals withdrawing from alcohol or other drugs in the broader community. The insights of our steering committee and expert panel complement the available evidence with expert opinion.

A limitation of our consensus statement is that it does not include the perspectives of people with lived experience of incarceration. Similarly, our expert panel did not include representatives of Aboriginal community-controlled health organisations. NPAMN acknowledges the important leadership of First Nations and lived-experience organisations in efforts to reduce harms associated with incarceration. NPAMN aims to support community-led work to improve health outcomes among First Nations people, and will continue efforts to build collaborative relationships to this end.

Drawing from a multidisciplinary expert panel representative of each of the states and territories in Australia, this consensus statement offers a high level of agreement regarding clinical and organisational elements of managing withdrawal from alcohol and other drugs in Australian custodial settings.

Withdrawal from alcohol and other drugs represents only a subset of substance-related risks faced by people entering custody in Australia. Instructive Australian consensus statements regarding harm reduction in custodial settings include those endorsed by the National Prisons Hepatitis Network and by the Harm Reduction in Prisons Working Group [62, 63].

The recommendations set out in this statement should serve as a reference for custodial services, health services and government to reduce morbidity and mortality related to withdrawal from alcohol and other drugs among people who experience incarceration. Improving the wellbeing of incarcerated people who use alcohol and other drugs requires not only safe withdrawal care but also implementation of evidence-based harm reduction strategies, assertive and responsive transitional care and stringent quality assurance mechanisms in custodial health services.

Author Contributions

Thileepan Naren conceptualised the project. Jocelyn Chan and Thileepan Naren managed project administration. Grace FitzGerald was responsible for the literature review and subsequent data curation, as well as writing the original draft. Thileepan Naren, Jocelyn Chan, Jon Cook, Mark Stoove, Michael Curtis, Suzanne Nielsen and Rebecca J. Winter provided significant contributions in review and editing.

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Data Availability Statement

The authors have nothing to report.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** mja270225-sup-0001-supinfo.pdf.