SUBSTITUTION TREATMENT IN PRISONS

Initiation of substitution treatment in prisons

Historically there has been limited availability of opiate substitution treatment in prisons. However the principle of equivalence with health care offered in community settings would suggest that substitution treatment should be available and accessible to all prisoners according to their health needs. Since many prisoners experience immediate relapse after release they should have an informed choice of either detoxification or maintenance.

Given the often relapsing/remitting nature of opiate dependence, detoxification alone is only effective in producing long-term change for a minority of users. The benefits of substitution treatment programmes can be maximised by:

- retaining clients in treatment;
- prescribing higher rather than lower doses of methadone;
- orientating programmes towards maintenance rather than abstinence;
- offering counselling, assessment and treatment of both psychiatric co-morbidity and social problems;
- using and strengthening the therapeutic alliance between clinician and patient to reduce the use of additional drugs.

There are three scenarios where it may be appropriate to initiate users onto opiate maintenance in the prison setting. These are:

- immediately upon admission to prison;
- during the sentence;
- a period of time before release.

Several studies have shown that here is an extremely high risk for drug using prisoners to relapse and overdose shortly after release. Overdoses on release and suicides in prisons were key elements in some countries to integrate ST in prisons. In order to avoid relapse and overdose post prison release, it is recommended that the prisoner is maintained on a small stable dose until released.

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Detoxification

Some drug users are successful in achieving a permanent state of abstinence whilst in prison. However, detoxification alone is seldom effective in producing long-term change for the majority of drug users. The benefits of methadone maintenance programmes can be maximised by retaining clients in treatment, prescribing higher rather than lower dosages of methadone, orientating programmes towards maintenance rather than abstinence, offering counselling, assessment and treatment of psychiatric co-morbidity, and social treatments and strengthening the therapeutic alliance between clinician and patient to reduce the use of additional drugs. It depends on several factors whether detoxification programmes or continuity of substitution therapy is offered/applied in prisons.

Institution related factors are e.g. lack of resources and/or personnel, which results in a limitation of the treatment places available, poor knowledge, lack of supporting regulations and guidelines, dependence on the development of substitution treatment in the community, opposing substitution policy for the prison setting or restrictive substitution policy outside in the communities. Patient''related factors: Sometimes prisoners wish to detoxify quickly and become completely drug free; they do not wish to have contacts with drugs and drug users anymore or to hear or talk about dependence and drug related problems. They either intend to utilise imprisonment as a drug free period or wish to start a new life and be ready and 'clean' upon their release from prison. However doctors and nurses can sometimes be opposed to such a goal when they feel that the prisoner's timescales for detoxification are too rapid, too ambitious and therefore not realistic. Relapse with a risk of overdose are likely to happen, in particular when detoxification occurs too fast.

One key element is to choose an individual approach in that sense that the doctor explains clearly to the patient the advantages and disadvantages of a quick versus a long detoxification.

Relapses after detoxification are extremely common and detoxification on its own therefore rarely constitutes adequate treatment of substance dependence. The options include managing withdrawal on admission as gradual detoxification, proceeding to abstinence-oriented treatment or proceeding to longterm substitution maintenance. Successful outcome of interventions requires that they are as client-tailored as possible and applied by using a case-by-case approach.

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It is important to accept that drug users are a very heterogeneous population. Their needs may be different according to the stage they are at in their drug using career, their level of self-efficacy and their degree of social support. Such factors may contribute to the preference of a faster rather than a slower reduction scheme. The treatment needs may also be different for women than they are for men.

Dosing and supervision of intake

As there is no such a thing as average dosage, dosage questions should be left up to the doctor-patient-relationship and should be adjusted according to individual needs. However, there should be the possibility and sufficient time to negotiate the needs of the patients to either reduce or increase dosage.

Each patient presents a unique clinical challenge, and there is no way of prescribing a uniform best methadone dose as a 'gold standard' for all patients to achieve a specific blood level. Clinical signs and patient-reported symptoms of abstinence syndrome, and continuing illicit opioid use, are effective indicators of dose inadequacy. There does not appear to be a maximum daily dose limit when determining what is adequately 'enough' methadone in MMT.

The dose has to be adjusted to a level that can reduce craving and then block any use of heroin as an euphoriant.
For dosages and more detailed regime suggestions (short or long term detoxification or maintenance) please refer to the EuroMethwork Methadone Guidelines – http://www.q4q.nl/euromethwork/home/publications/methadone-guidelines/

In contrast to community treatment settings, relatively low dosages might be sometimes sufficient in the prison setting for two reasons:

1. in the prison the universal supervision of intake guarantees an almost 100% consumption of the substitute medication and
2. the amount of other drugs taken is substantially reduced compared to the situation in the community.

Research indicated that the average substitute dose varied considerably in prisons (from 30 to 70 mg). In contrast to community practice, some doctors believed that low doses were sufficient on the basis that 100% intake was guaranteed and that the amount of other drugs used is significantly lower in prison.

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Prisoners should be informed about the dose they are prescribed unless they specifically request not to know.

The supervision of intake (of methadone either in liquid or tablets) is organised in different ways, done either by nurses or guards, depending on how and where the substitution drug is dispensed: either within the medical unit or on the cells/wards. This is to ensure that the substance is swallowed completely. In most cases, control is carried out by letting patients talk afterwards. In some setting the guards dispense the medication, when there is no medical staff on duty. There is a consensus that the intake of substitution drugs (as well as the intake of other psychoactive substances, antidepressants etc.) has to be supervised in order to make sure the drug has been swallowed adequately and to avoid other prisoners blackmailing patients in methadone programmes to sell or provide their portion, and finally to avoid overdoses from prisoners with no opiate tolerance.

Dispensing of buprenorphine may require quite some time.

Urine controls

The assessment and consequences of medically ordered urine controls vary considerably.
Urine analysis is an issue that has been much debated in the field. Although urine controls are a vital part of the initial medical assessment of the patient (for confirmation that the patient is actually using opiates), they are often used as a form of control over patients to see if they are not continuing to use illegal drugs with their medication. Many professionals question its effectiveness as a positively contributing factor to the success of treatment. It is argued that the information can also be obtained by asking the patient, which would save a lot of time and money. It goes without saying that this requires a good patient-doctor relationship which is based on respect and mutual trust.

However, it is also argued that a positive urine sample should never be a reason for discontinuing treatment, since this is the evidence for symptoms of the condition the patient is being treated for, i.e., their drug dependence.

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Dropping out of substitution programme

If a patient abuses or manipulates the substitution medications, in some programmes he/she can be excluded from the substitution programme. However, it is very important that the patient has been included in the substitution programme for a sample period of time, and that his/her dosage was high enough.

Some other programmes exclude patients because of being physical or even verbal violent against co-patients or staff. In this case the dosage should be tapered gradually.

Substitution treatment should never be a kind of reward for good behaviour or withheld as punishment but a part of a normal treatment within a variety of medical and psychosocial options.

The role of psycho-social care

The combination of physical, psychological and social dimensions contribute to the complexity of drug dependence. In order to successfully treat the disease and overcome drug dependence, it is necessary to address both, the physical and psychosocial dimensions of the disease. For many dependent drug users this may entail substantial physical, psychological and lifestyle adjustments – a process that typically requires a lot of time.

Substitution treatment, therefore, must not only deal with the opiate addiction on its own but also with psychiatric, medical and social problems.
Psycho-social care is therefore regarded as an additional and necessary part of treatment to support the medical part of the substitution treatment in prison.

Co-prescription of benzodiazepines and use of other drugs

The use of other drugs is widespread among drug users, mostly to bridge the gap between the lack of availability of the preferred opiate (merely heroin) use. The using patterns often constitute an additional dependence with severe syndromes and problems in detoxification.

People with opioid dependence and IDUs frequently use a range of psychoactive substances in addition to opioids, including alcohol. Research has shown that the use of cocaine in combination with opioids is, in particular, a factor that is associated with treatment failure. In addition, where drugs such as cocaine are used by injection, the effectiveness of opioid substitution therapy in managing risk behaviours is reduced. At the same time, research evidence indicates that when

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individuals with opioid dependence are retained in treatment, levels of use of cocaine are reduced, along with levels of opioid use.

Box 3: Substitution guidelines for penal institutions in Austria

(Adapted from Pont J, Spitzer B, Resinger E, 2005)

Purpose of substitution:

1. Emotional and physical stabilisation of severely opiate addicted individuals
2. Minimisation of drug related crime and debt
3. Reduction of intravenous opiate consumption and of transmissible diseases (hepatitis B/C and HIV/AIDS).

Substitution strategies:

- Long-term substitution: for months, years or for life-time
- Interim substitution: substitution on temporary basis until a well-planned treatment and withdrawal.
- Reduction substitution: substitution medication is carefully reduced step by step.

Substitution medication: use only drugs that are effective for at least 24 hours and are administered orally once a day:

1. Methadone is prepared and administered "magistraliter" as a syrup in order to make intravenous usage more difficult. The dependence potential is very high. The average oral maintenance dosage is around 40–100 mg a day. A dose exceeding 120 mg is not recommendable. Introductory dose: 30–40 mg daily, boosting by approx. 10 mg per week; tapering by 5–10 mg per week
2. Buprenorphine is a partial opiate agonist and antagonist to be administered sublingually once a day. Daily dose ranges between 8 mg and 32 mg. In contrast to other substitution drugs, patients remain rather lucid. This creates problems for those patients who clear-minded cannot stand themselves due to their psychosocial co-morbidity. The major reported side-effect is headache. When switching from pure opiate agonists to buprenorphine, it is important to stop the agonist for one day before starting buprenorphine, in order not to cause acute opiate withdrawal symptoms.
3. Slow release morphines are administered as tablets or capsules. The average morphine dose is around 600 mg per day, the highest recommended dose being approx. 800 mg. Patients on anti-retroviral therapy sometimes require a dose of up to 1200 mg due to drug interactions. The introductory dose is 200mg, boosted or tapered by 30–60 mg per week. The range of side effects attributable to retarded morphine is less than with methadone (less depression, less apathy, less increase in weight).

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Drug interactions

With all opiate medications, interactions must be taken into consideration, in particular those due to competitive inhibition or induction of cytochrome P 450: The antibiotics ciprofloxazin, erythromycin, clarithromycin, oral contraceptives and SSRI (especially fluvoxamin) increase the opioid effect, while the HIV virostatics neviparine, efavirenz, nelfinar/ ritonavir and rose of Sharon decrease it.

Obligatory agreements with the patient:

1. Declaration of consent and registration at the addictive drug monitoring department
2. Visual monitoring of the administration
3. Consumption control by means of urinalysis
4. Regular care support by treatment consultants
5. Exact information about substitution medication and the dangers of misuse and of accompanying consumption of other drugs

Indications for substitution:

1. The patient is already on substitution treatment when entering the penal institution
2. The patient has been dependent on opiates prior to imprisonment, and cannot withdraw inside the penal institution
3. The patient became dependent on opiates during imprisonment, and in spite of several withdrawal therapies, has not succeeded in becoming clean.

Security measures:

1. Exact control of administration of the substitution medication by medical staff
2. Obligatory random urine tests by medical staff

Ethical basics of substitution:

Addiction is a chronic recurring illness. The optimal goal of therapy, cure, hardly ever is achieved. Modern addiction therapy is increasingly based upon the term harm reduction, i.e. reducing suffering, completed by precise clarification and treatment of psychosocial co-morbidities. When choosing substitution medication, cost awareness is of course an issue, i.e. methadone is the first choice. In case of severe side-effects of methadone, a switch to another better tolerated medication is to be considered. Patients successfully on substitution before imprisonment should continue the same medication in prison. Relapses should not lead to termination of substitution treatment as relapses are inherent in addiction. Instead, they should lead to a reassessment whether the treatment can be optimized. In particular, it should be clarified whether the medication dosage is sufficient. If relapses continue to occur in spite of a higher dosage, it might be necessary to switch to a different substitution drug. However, if a patient repeatedly misuses or diverts the prescribed substitution

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drugs he should be gradually withdrawn from the substitution program as obviously he is lacking the necessary motivation and discipline.

References

Pont, J. (2005): Medical ethics in prisons: Rules, standards and challenges. International Journal of Prisoner Health 2:259-267.

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