

SOME BASIC INFORMATION ABOUT TREATMENT

Information users require

The absolute condition for an effective start of substitution treatment is to provide the user with relevant information, in particular on the risk of overdose, which should include the following:

- the delay of a peak effect of the substitute drug (methadone 2–4 hours);
- the accumulation of the substitution drug over time resulting in a greater effect (methadone over 3–5 days or more), even on a fixed dose;
- the risks of multiple drug use while in substitution treatment, especially other opiates, cocaine, benzodiazepines and alcohol; and
- the potential interaction with other medication.

In addition, users need information about substitution treatment and drugs in general and about particular rules and expectations. Drug users often do not understand the goals pursued with the substitution treatment, nor do they have enough information about the specific medication used or the rules they have to follow. Prisoners should be asked to sign an informed consent form once they have clearly understood all relevant information.

Anonymity and confidentiality of treatment

Every prisoner should know before getting any sort of treatment the primary physician's obligation: to the state, to the prison or to the prisoner.

Although securing anonymity and confidentiality within a prison is difficult, attempts have been made to administer substitution drugs in a way that protects prisoners, either by putting all drug users together in one wing or delivering substitution drugs discreetly with other pharmaceuticals.

Other prisoners and staff should not be made aware that a prisoner is a drug user or in substitution treatment. The fear is that if somebody knows about the drug dependence, it will lead to consequences for the actual sentence in terms of disadvantages (such as access to work, qualification or jobs), prejudices, loss of privileges or simply the negative attitude of staff and other prisoners. Moreover, the drug users fear pressure from other prisoners who wish to participate in the substitution treatment in terms of smuggling substitution drugs.

However, informing properly trained guards and other staff involved in work with the prisoner can be useful, particularly in the observation of patients with particular vulnerability due to co-



existing mental health problems. Shutting guards completely out of the psychosocial and health care support also seems to build barriers between the different professionals and sometimes enhances prejudices and misunderstandings about the prisoner and drug use. Hence, basic cooperation, information and training of prison staff, including guards, are needed to ensure that staff members have positive or at least better attitudes towards drug users.

Privileges

Patients on substitution treatment who follow the rules in their therapeutic agreement should be able to enjoy all the same privileges as other prisoners. Decisions regarding flexible release should be made based on the therapist's individual judgement. Flexible releases should be planned and performed gradually.

Take-home dosages can be given as privileges for visits or periods of leave outside prison that are longer than 24 hours. The prisoner receiving the substitution treatment must be able to continue with such treatment and must have the possibility of being included in other programmes after release. The physician decides about patient's ability to work for those included in substitution treatment programmes in prisons.

Box 4: Continuing opiate maintenance between the community and prison treatment settings

Patients who are on opiate maintenance therapy prior to admission to prison should have their medication continued inside prison. However there are many barriers to such continuity of care. The most significant barrier is that many patients have their maintenance therapy interrupted if they spend time in police custody prior to prison. This can result in significant loss of opiate tolerance. Wherever possible users should have their opiate maintenance therapy continued at their prescribed dose whilst held in police custody. One exception to this principle is when the user is intoxicated at the point in time when he/she is due their daily dose of maintenance drug (note if patients are arrested intoxicated this should not be the reason for withholding maintenance therapy). Also if the user enters police custody outside of normal working hours when it is not possible to confirm with the community drug/pharmacy service the user's reported dose (typically at the weekend) then the dose administered in the police cell after physician's examination should not exceed 30mg and should only be given following confirmation of recent use by an on-site urine or oral fluid sample that is positive for opiates.



There is a need for a joined up approach to ST in the criminal justice system as currently even where prisons are offering ST most police forces do not provide ST or withdrawal treatment. This can be particularly problematic where detainees do not go direct to prison but to Police Arrest Houses where they can stay in some countries for up to 6 months (or even longer) and then to prison.

Another difficult situation is when detainees go to the arrest house, then to prison and then back to arrest houses to attend court for example and then back to prison. Generally police are under the Ministry of the Interior while prisons are under the Ministry of Justice which makes in some countries cooperation even harder.

ST should be negotiated with community agencies, police, courts, prisons and probably Ministry of Health in order to provide seamless substitution treatment provision for those with problematic drug use.

For users admitted to first night prison reception purporting to take methadone maintenance therapy, confirmation of their dose, level of supervision and time of last consumed dose should be sought from the community drug service/pharmacist. If such confirmation can be obtained that the user has received their full dose supervised within the last 48 hours then the user should be provided with maintenance therapy at the dose level he/she received in the community. However, obtaining such confirmation is often not possible as patients are admitted to prison outside of normal working hours. In such circumstances the initial dose of methadone after physician's examination should not exceed 30mg (for other low/uncertain users until the confirmation is received). However for those admitted claiming to be taking a high dose of methadone, it could be necessary to offer a period of intense observation where emerging withdrawal symptoms can be monitored and the dose titrated accordingly.

Users' involvement

Ongoing contributions from drug users are valuable in order to improve the quality of health care; most prisoners have had previous, personal experience of prison health care and substitution



treatment inside prison and in the community (either detoxification or maintenance).

Acknowledging and integrating prisoner's experiences and expertise in involving drug users in developing, designing and delivering interventions is critical to increasing their appropriateness and reach.

Support groups or educational programmes should be established or incorporated into the overall HIV treatment programme for injecting drug users. Former injecting drug users often have unique success in educating and motivating current injecting drug users to take steps to access effective care.

The link with treatment of blood borne viruses (e.g. HIV/AIDS, HBV, HCV) and other infections (e.g. TB, STIs)

Substitution treatment offers opportunities for improving the delivery of antiretroviral therapy to opioid users living with HIV. Substitution treatment enables opioid-dependent drug users to stabilise their lives and avoid or manage many of the complications of injecting drug use. It is therefore seen as an essential component in strategies for retaining active injecting drug users in treatment. It also provides additional entry points for scaling up antiretroviral therapy, improves drug adherence and increases access to care.

Substitution treatment programmes can be of great importance to injecting drug users living with HIV by:

- offering HIV testing for injecting drug users;
- referring them to HIV services;
- liaising with HIV services regarding treatment and care;
- preparing injecting drug users for treatment with antiretroviral therapy;
- stabilising an injecting drug users' drug dependence to a point where he or she is able to engage in antiretroviral therapy
- dispensing antiretroviral therapy in conjunction with opioid substitution treatment;
- monitoring and managing the side effects of antiretroviral therapy;
- monitoring and managing interaction between methadone or buprenorphine and antiretroviral therapy; and
- supporting individual and family through the lifelong commitment to antiretroviral therapy.



This daily contact with substitution treatment programmes has potentially huge advantages for access and adherence to antiretroviral therapy.

Substitution treatment offer in all stages of the criminal justice system

Substitution treatment may also play an important role in police detention and pre-trial detention institutions. Those addicted to heroin or other opioids and being caught and arrested by the police and brought to police detention houses may face severe withdrawal symptoms. These may influence the information given to the police and may also prolong the stay in these facilities. Substitution treatment should be offered as a form of through care, which provides stability to the health status of offenders both physical and mental. Risks over overdose by using drugs in these facilities after a short period of detoxification may also be very harmful, as the opioid addicts lose the opiate tolerance within days, which then may lead to increased risks. In how far substitution treatment may also contribute to a decreased risk of suicide or self harm have not been studied yet. But a positive impact on these phenomena mostly occurring within the first weeks of imprisonment is quite likely.

The same accounts for institutions of pre-trial detention and remand prisons. Therefore existing substitution treatments should be continued in police detention and pre-trial detention centres and remand prisons. Moreover home leave, holidays etc. are periods in which basic rehabilitation steps are being undertaken, but also the risk for relapse is increased. ST also provides stability in terms of overdose-prevention.

Special considerations for women

Women tend to have a different experience than men with both drug dependence and treatment. Major issues are related to the high levels of both physical and mental comorbidity of women with opioid dependence, and these need to be taken into account in providing treatment. Women with opioid dependence often face a variety of barriers to treatment, including lack of financial resources, absence of services and referral networks oriented to women and conflicting child-care responsibilities.

Effective substitution treatment of opioid dependence can substantially improve obstetric, prenatal and neonatal outcomes. Opioid substitution maintenance therapy also has an important role in attracting and retaining pregnant women in treatment and ensuring good contact with obstetric and community-based services, including primary care.



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