FUTURE PERSPECTIVES

In order to ensure that prisons provide a level of care equivalent to that provided outside,

- a major expansion of care for blood borne and sexually transmitted infections is needed in many countries to meet the needs of prisoners,
- substantial efforts have to be made to improve the quality of services and
- better links and continuity of care are needed between prisons and the range of community-based services.

The 2002 Consensus Statement on Prisons, Drugs, and Society (WHO Regional Office for Europe and Pompidou Group of the Council of Europe, 2002) recognizes that:

- drugs and prisons have to be seen in the wider social context;
- people move between prisons and the community;
- imprisonment should not mean more punishment than the deprivation of liberty;
- prisons must be safe, secure and decent places in which people live and work; and
- people working in prisons must work within the law as it stands.

Given the existing evidence of the growing problems of injecting drug use and HIV/AIDS in prisons and of the effectiveness of substitution treatment, the time to act is clearly now. Failure to implement effective drug treatment, including substitution treatment, and measures to prevent HIV transmission will result in further spread of HIV infection among injecting drug users, the larger prison population, and ultimately, in the community outside prisons.

MEDICAL ETHICS ASPECTS OF OST PROGRAMMES IN PRISONS

There are three reasons why it seems appropriate to discuss ethical implications of opiate substitution treatment in prison, a treatment as solidly based on scientific evidence as any other accredited medical treatment and that is in line with WHO and UN recommendations [WHO, United Nations Office on Drugs and Crime and UNAIDS, 2004] and with many national legislations:

1. Drug addiction is subject to strong ideological and cultural conceptions. The adverse influence of ideological conceptions on treatment approaches and treatment goals of drug addiction brings addicted patients in a position that their access to treatments and the choice of treatments often are decided on ideological rather than medical considerations.
2. To avoid misuse and diversion of opiates, the prescription of opiates underlies strong legal regulations that impair confidentiality and for the same purpose the delivery of opiates to addicted patients affords control measures that add a peculiar coercive component to the patient-physician relationship.

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3. Both above statements become all the more complex in the ethically challenging interaction between prisoner patient and prison doctor as well as in the totalitarian institution prison [Pont J, 2006].

In the following ethical aspects of opiate substitution in prison will be explored on the basis of the principles of medical ethics in prison as established in the European Prison Rules [Council of Europe 2006], in the Standards of the European Committee for the Prevention of Torture (CPT) [Council of Europe 2004] and in several other internationally consented documents by the UN and the World Medical Association. The essence of medical ethics in prison and of the quoted documents can be summarised as follows:

- The primary task (the sole raison d'être) of the prison doctor and the other health care workers is the health and well-being of the inmates. [Council of Europe 1999, Penal Reform International 2001]
- The seven essential principles for the practice of prison health care, as set out by the CPT standards are:
    1. Free access to a doctor for every prisoner
    2. Equivalence of care
    3. Patient consent and confidentiality
    4. Preventive health care
    5. Humanitarian assistance
    6. Professional independence
    7. Professional competence

The European Prison Rules can be found at https://wcd.coe.int/ViewDoc.jsp?id=955747
More information on the European Committee for the Prevention of Torture (CPT) can be found at http://www.cpt.coe.int/en/about.htm

It is important that prison physicians and health care workers stick to these principles and that they are made known to and accepted by the whole prison community, i.e. the prisoners, the staff and the prison administration. Compliance with these principles promotes the confidence of the inmates to the medical care in prison, leaves no doubt as to the doctor's medical professionalism and ethics, prevents misunderstandings and provides guidance in situations of conflicts.

It seems to be perfectly natural that the primary task of the prison doctor is the health and well being of the inmates but, as every health care practitioner in prison knows, it has to be continuously fought for and this is true also for the implementation and realisation of opiate substitution programmes in prisons. Prison administrations and non-medical staff, if not

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adequately informed on the evidenced benefits of this treatment, focus on the risks of misuse and diversion of opiates and tend to counteract substitution programmes. In keeping with A) it is due to the prison doctor to provide this information, help the security staff and administration to understand the goals of the treatment, overcome any misconceptions and enable that way opiate dependent prisoners to have access to proper opiate supported treatments.

Prisoners may be ordered to undergo urine tests for drug metabolites by the security staff for safety and security grounds. Urine tests are also a component of treatment contracts in many opiate substitution treatment programmes. Doctors and health care workers caring for inmates might be asked to carry out clinical urine analyses by the security staff as well when there are concerns over a prisoner's safety. Keeping in mind A) and the importance of trust and confidence of their inmate patients, doctors and health care workers caring for prisoners must never participate in drug testing for security reasons. It is of utmost importance that inmates are clearly informed about the difference between urine testing for security reasons and for therapeutic reasons and that the results of urine analyses within the substitution treatment programme are kept strictly confidential, serve only for treatment recommendations and will never cause punishment. These results should only ever be disclosed beyond the clinical team with the patient's express consent and where it can be deemed to be in the best interest of the prisoner to do so.

Another important principle of current treatment concepts for drug dependent patients fits well with the wording of A): The treating physician must not only take care that the agreed-on treatment goals – both in the short and in the long run – are achievable for the individual patient but also that the physician's own ideas on human dignity and way of living do not sway the treatment goals set with the patient. It is the health and well-being of the inmate patient what is the task of therapy and not necessarily the adjustment of the patient's way of life to the therapist's life style.

The claim for access and equivalence – the first two points of B), the essential principles of the CPT – of opiate substitution treatment in prison has already been raised by the WHO in 1993 (WHO 1993) and has been underlined since repeatedly (Lines R et al 2004). There are still European countries where opiate substitution maintenance programmes are run in the community but not in prisons and sometimes in jails and prisons there is even no opiate supported detoxification available. Any abrupt opiate withdrawal – particularly methadone withdrawal – without opioid support ("cold turkey") amounts to medical malpractice and is absolutely incompatible with medical ethics and medical professionalism!

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The number of opiate substitution treatment programmes in prisons in Europe and elsewhere has increased considerably during the last decade but there still prevails a gap between prisoners requiring substitution maintenance treatment and those receiving it (Stöver/Casselmann/Hennebel 2006).

This gap denotes not only a shortcoming of treatment options and harm reduction chances for the individual prisoner patient but also a threat to public health: of all the places where drug users inject drugs, prisons are those where injecting is associated with the highest risk of transmission of blood borne viruses. This high-risk situation translates into a greater than equivalent need of harm-reducing strategies in prison than in the community (Lines 2006).

In several countries more than one opioid medication is now used in opiate substitution programmes. Not only for the ethical principle but for very practical reasons equivalence between community services and prisons and between prisons should be aimed at also in this concern in order to avoid changes of treatment in the most sensitive phases of imprisonment, prison transfer and release from prison.

Access to opiate supported treatment and equivalence must also be sought for female drug users in prison. Due to the low numbers of female prisoners in comparison to males, in many countries there exist far fewer services and treatment chances for female prisoners. Given their comparatively greater physical and mental co-morbidities and their higher HIV prevalence rates, female drug users in prison might need greater than equivalent treatment options than their male counterparts. Due to their specific experiences with addiction and its treatment they might also need different treatment patterns. Substitution treatment plays an important role in pregnancy and peri-natal care of opiate dependent women by reducing the risks for mother and child.

Access to uninterrupted continuation of opiate substitution maintenance treatment at a community treatment service after release is of crucial importance considering the excessive mortality of drug users in the first two weeks after release from prison that is caused predominantly by drug overdose (Christensen et al. 2006). Besides pertinent education of pre-release prisoners, continuity of substitution treatment in the community must be thoroughly planned and arranged in good time by the prison health care team prior to the release of the prisoner.

Consent of the adequately informed patient – “informed consent” – is a prerequisite to any treatment containing adverse side effects and/or risks of which there are several in prescribing opiates. Due to the complexity of opiate substitution treatment in medical, legal and psychosocial terms, many substitution programmes do not rely on verbal or written informed consent of the

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patient, but opt for a formal contract to be signed by the patient and the therapist. It should be kept in mind that there are few if any other treatments where a contract is required from patients and this might add an element of coercion and mistrust to the patient-physician relationship. On the other hand, a contract underlines the agreed-on obligations of patient and therapist to be mutually reminded or demanded and, if this is an individually tailored contract which is explained and discussed properly, it will enhance the understanding of opiate substitution and the individual treatment programme and treatment goals, but should never be used punitively. A recent survey (Stöver/Casselman/Hennebel 2006) showed clearly that there is a need to improve understanding in patients by better information.

Minimal requirements of information before entering a patient into a substitution programme might include the following:

- Any obligation the physician has toward a third party that impairs confidentiality (notification to authorities according to the law or to the court) but also all those areas where the patient can count on strict medical confidentiality
- The rationale of opiate substitution treatment
- The obligations of the patient and the therapist as agreed
- The individual current treatment goal as elaborated with the patient
- Risks, unwanted side effects and possible restraints
- What is likely to happen if the patient deliberately stops treatment
- How to deal with relapses
- What might cause the termination of the participation in the substitution treatment

Given the long term treatment nature of opiate substitution treatment and the adaptations of treatment goals and changes of treatment strategies in time, information, informed consent and/or contract must continuously be adapted: “continuous informed consent”.
The patient is asked also to consent to control measures like the check of the oral cavity after ingestion of the substitution drug in order to attempt avoiding misuse and diversion of opiates, which is given special importance in prison. This is to be regarded as part of the treatment programme and should be carried out by the medical staff and not by the custodial staff. The same is true, if urine analyses are included in the programme the results of which have to be kept strictly confidential and serve only for therapeutic and never for disciplinary decisions. But, as mentioned earlier, medical staff should never carry out or participate in body searches or urine analyses that are ordered by the custodial staff for security, i.e. non-medical reasons.

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Confidentiality for prisoners participating in opiate substitution programmes is often limited for legal and for practical reasons: National law requires notification of persons who are prescribed opiates in most countries. In prison, the supply and delivery of opiate substitution drugs as well as the shortage of medical staff often requires the inclusion of and cooperation with security officers, a measure that hampers strict medical confidentiality for drug users. Comprehensive drug treatment needs interdisciplinary cooperation where sharing of information and records is unavoidable and in the interest of the patient. Every member of the treatment team is to be bound by professional confidentiality. It is of great importance that patients are well informed as to who will have access to their records, who is included in professional confidentiality and where are the de facto limitations of confidentiality.

Drug users in prison are interested to conceal their drug dependence for several reasons: they anticipate disadvantages in terms of placement, privileges and access to work; they fear prejudices and discrimination both by inmates and by staff – and sometimes even by health care workers! – and they can become victims of pressure and blackmailing as soon as their drug dependence is known to others. When participating in substitution treatment programmes they are often pressed to divert the prescribed drugs to the black market in the prison. For all these reasons every endeavour should be made to protect drug users and participants of opiate substitution programmes in prison by maintaining good standards of confidentiality and by getting rid of discriminating regulations, behaviours and attitudes against them. In particular, the participation in an opiate supported treatment programme must never lead to any discriminating disadvantage while serving the prison term.

As to preventive health care, opiate substitution maintenance treatment represents the classical example of an effective prevention and harm reduction measure for the individual opiate drug user as well as for the society inside and outside prison walls: the abundant evidence on prevention of mortality, morbidity, personal suffering, social instability and criminal activity is well documented and a preventive impact on HIV and Hepatitis B and C transmission by reducing high-risk drug injecting behaviour in prison is more than likely.

Humanitarian assistance as quoted by the CPT relates to particularly vulnerable prisoners. In a sense drug users in prison belong to the group of vulnerable prisoners as they rank low in the prisoner hierarchy, face prejudices by inmates and staff, run the risk of getting into debt with subsequent threats of bullying, violence, coercive sex work and pressure to divert prescribed drugs. Some of these problems can be avoided by keeping strict confidentiality and providing appropriate treatment of the drug dependence but often sensible placement changes and additional protective measures may become necessary: Encouraging prisons to see this treatment as a “normal” part of prisons routine and in line with other medical treatment interventions offered will certainly make life of drug users in prison easier.

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Juveniles, female drug users, especially pregnant drug using women, and members of ethnic or cultural minorities are in need of additional protection and assistance. There is an increasing number of foreign-language speaking drug users in European prisons who need interpreter services during assessment and counselling. Beyond language barriers, the wide-spread psychiatric co-morbidities and cognitive impairment in imprisoned drug users poses additional challenges to treatment of drug dependent prisoners.

In fear of misuse and risks, regulations and decrees by national health authorities or by prison administrations have been trying repeatedly to limit professional independence in opiate substitution maintenance treatment by narrowing indication boundaries or by lowering the maximum doses or length of treatment. Apart from the fact, that state authorities have no say in indications or doses of treatments, experience has shown that lower threshold programmes, higher doses and longer treatments have been yielding better results. Issues such as the indication to treat, the maximum dose and the length of the treatment should be left to the experienced drug therapist's judgement based on the individual assessment of the patient and mutual agreement.

There seems to be a need to improve the information to patients, that substitution treatment in prison is a medical treatment independent from custodial measures: In a recent survey (Stöver/Casselmann/Hennebel 2006) this treatment was sometimes perceived by prisoners to be a favour or reward to good behaviour from the prison rather than a health treatment from the medical service. The clarification is particularly important in those patients who are sentenced by the court to undergo treatment for addiction while serving their prison term.

Any treatment of drug dependence requires solid professional competence. Given the complex nature of opiate substitution treatment in prison, the responsibility of individual assessment and treatment planning and the obligation to keep fatal risks and unwanted side effects as low as possible, every health care team in prison that offers opiate substitution treatment should involve a doctor specialised in substance dependence treatment.

Opiate substitution should be seen as one part in a range of treatment offers for drug users and should enable or facilitate the inclusion of drug users to further treatment options. However, as has been shown by the quoted survey [Stöver H, Casselmann H, Hennebel L, 2006], in a majority of prisons there is a lack of psychosocial care due to shortage of resources, in which case substitution treatment tended to be just a prescription of opiates that caused considerable dissatisfaction both to patients and to doctors.

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In order to minimize diversion and misuse of opiates, control measures are unavoidable. These include the inspection of the oral cavity after administering the prescribed opiate and in many substitution programmes also urine analyses for drug metabolites periodically. These checks should be carried out by the medical staff and under conditions that uphold confidentiality. Research has been unable to demonstrate that urine testing is a reliable effective way of monitoring drug use. A therapeutic, open and trusting relationship is likely to produce a more accurate and productive indication of drug-using patterns.

The direct visual control of urinating is humiliating and not compatible with a respectful patient-relationship. Results of urine tests must be kept confidential and should serve solely for clinical decisions.

In order to improve the quality of opiate substitution programmes in prisons, health care teams should:

- try to become appropriately staffed
- have an interdisciplinary approach to drug treatment programmes
- adhere to examples of best clinical practice
- monitor and evaluate treatment results by adequate recording
- ensure continuity of care for patients to be transferred or released
- consult service users and incorporate their views when developing services
- be responsive to the diverse needs of all drug users in prison
- engage in training of medical and non-medical staff
- communicate regularly with health care teams of other prisons and of community based services involved in treatment of drug users
- undergo regular supervision and
- participate in research for optimisation of treatment.

Opiate supported treatment of drug users in prison is a valuable and scientifically well evidenced treatment option with a proven harm reducing effect on individual health and public health. Thus, it is highly recommendable in terms of medical ethics. Those who uphold ethical reservations against prescribing drugs that maintain the dependence of drug users and who accredit only abstinence as treatment success in drug dependence should reassess whether this sublime treatment goal, rarely to be achieved in the short run, outweighs the tangible reduction in mortality, morbidity, personal suffering, social instability and criminal activity in opiate substitution maintenance treatment

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