

Agonist Opioid Treatment in Prisons*

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Summary

It is estimated that approximately one third of prison inmates can be considered opiate-dependent, and that many more are experienced drug users. In several prisons, this includes up to three quarters of the inmate population. Prisons are extremely high-risk environments for HIV transmission because of overcrowding, poor nutrition, limited access, continued illicit drug use (“unhygienic relapses”) and unprotected sex. As to recidivism among substance abusing prisoners, between 70 and 98 % of those who have been imprisoned for drug-related crimes, but did not receive treatment during their imprisonment, undergo a relapse during the twelve months following their release. The recently published position paper WHO, UNODC and UNAIDS (2004) on agonist opioid maintenance therapy concludes that providing agonist opioid maintenance therapy in treating opioid dependence is an effective strategy for preventing HIV/AIDS, and that it should be considered for implementation as soon as possible in communities at risk from HIV infection. IDUs who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment. The death rate of people with opioid dependence in methadone maintenance treatment is between one third and one quarter the rate for those not in treatment. The health services for individuals in prisons or correction houses should have standards as high as those provided outside the correctional system.

Key Words: Health Services - Agonist Opioid Treatment

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Introduction

Estimates suggest that there are 13.2 million injecting drugs users worldwide, and that at least 10% of all cases of HIV infections worldwide result from unsafe injecting behaviour, in countries in Eastern Europe and Central Asia, the percentage is much higher, reaching levels as high as 90%.

It is estimated that approximately one third of all prison inmates can be considered opiate-dependent; many more are experienced drug users. In several prisons, this includes up to three quarters of the inmate population.

Evidence from the United States of America indicates that approximately 80 percent of IDUs have a history of imprisonment, and a 12-city World Health Organization study of HIV risk behavior among IDUs found that between 60 and 90 percent of respondents reported a history of imprisonment since they first began to inject drugs.

Prisoners often come from the poorest sectors of society and, as a result, suffer from health disadvantages from the start. Being in prison typically exacerbates existing health problems, especially with vulnerable groups such as drug users.

Prisons are extremely high-risk environments for HIV transmission because of overcrowding, poor nutrition, limited access, continued illicit drug use (“unhygienic relapses”) and unprotected sex.

Taken together, the costs of law enforcement, court time and imprisonment make a major contribution to the social costs associated with opioid dependence.

On release, prisoners with opioid dependence are at risk of relapse and overdosing.

As to recidivism among substance-abusing prisoners, between 70 and 98 % of those who have been imprisoned for drug-related crimes, but did not receive treatment during their imprisonment, undergo a relapse during the twelve months following their release.

Prisons systems have been found to be slow to respond to epidemics of viral infectious diseases (such as HIV and hepatitis) and drug use by injection. Agonist opioid treatment has been seen as a response to the dangers encountered by opiate-dependent inmates, as it can reduce (i) heroin use, drug injection and needle sharing, (ii) participation in the prison-based drug trade, (iii) opiate-related mortality soon after release from prison. It can lead to (iv) increased participation in drug treatment after release from prison, (v) a significant reduction in serious drug charges. Offenders participating in agonist opioid treatment displayed lower readmission rates overall. More broadly, the prison system benefits from a reduction in withdrawal symptoms upon admission, lower involvement in the drug trade and a rise in the productivity of prisoners.

In common with the evolution of agonist opioid treatment in the community, the service was first made available in prisons for inmates with HIV/AIDS, other infectious diseases and, in the case of women, those who were pregnant. Provision is still insufficient, behind the standards of agonist opioid treatment in the community. A treatment gap persists between those requiring agonist opioid treatment and those receiving it.

The studies now available indicate that continuity of care is required to maintain

any benefits that are acquired.

There are strong reasons for prison services to consider the introduction of agonist opioid therapy. These include:

- * The growing problem of suicide and self-harm during the period of withdrawal among imprisoned problematic drug users and drug-dependent people;
- * The importance of providing equal opportunities for treatment, in terms of linkages with therapeutic communities;
- * The drive to provide clinical services at a standard equivalent to internationally agreed best practice;
- * The risk of a fatal overdose in the first few days after release from prison, especially for short-term prisoners;
- * Problems experienced by staff in managing regimens and difficulties that arise during withdrawal, including drug smuggling and acts of violence toward staff and other prisoners.

Treatment

Arguments for provision of prison-based AOT

There are several valid arguments in favour of the view that agonist opioid treatment (AOT) should be provided to all individuals who have received MMT outside of prisons. This point is particularly relevant in the light of findings indicating that people who are taken off AOT once they are imprisoned often go back to the use of narcotics, usually within penal institutions, and often via injection. AOT can be used for detoxification purposes for opiate-addicted individuals as a means to reduce withdrawal symptoms and alleviate anxiety that emerges at the moment of entry into prisons. AOT reduces high-risk injecting behaviours among prisoners who inject drugs, so reducing the spread of the infectious diseases. AOT may help to increase prisoners' participation in abstinence-based treatment programmes within and outside of prisons. Provision of AOT for those nearing release may help to reduce risk for overdose, considering that many prisoners resume injecting once they are released from prisons, but do so with a higher risk of a fatal overdose, as a result of reduced tolerance to opiates. The provision of MMT may reduce the likelihood that newly released prisoners will return to crime, given the evidence that MMT reduces involvement in illegal activities, particularly among newly released prisoners.

Evaluations of prison-based AOT

- * Observed lower rates of heroin use, injection drug use and use of syringes compared to controls;
- * Reduced levels of drug use and participation in the prison drug trade;
- * Prisoners maintained on methadone reported lower levels of risk behaviour in prisons than untreated prisoners;
- * Addicted prisoners who received MMT in prison were more likely to seek drug

treatment upon release from prison than prisoners who received methadone for detoxification;

- * In Canada, the federal prison system enhanced access to MMT after evaluations demonstrated that MMT had a positive impact on release outcome and on institutional behaviour.

General instructions for treating drug users in prisons in Slovenia, EU

The health services for individuals in prisons or correction houses should be provided at a standard that is equivalent to those found outside the correctional system.

The professional independence of counsellors and therapists is a priority.

Close cooperation between the health care professionals in prisons and in communities must be established.

Addicted individuals must be given an option for treatment upon their entry into the prison system (the range might be: harm-reduction programmes, agonist opioid treatment, detoxification, drug-free treatment).

They must have the option of being treated in community programmes.

Limited access and quality of care

WHO recommends: "Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries where methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons".

In most countries, the most likely situation is that agonist opioid treatment will be discontinued on entry into prison. The reasons for this include:

- * The basically drug-free orientation to be found in prison staff; this seems to overlap with the purpose of the sentence – that of helping prisoners not to commit crimes any more (and drug users are most likely to commit crimes, simply because of their need to purchase drugs);
- * The perception of methadone (or any other agonist opioid drug) as a psychoactive drug that is unsuitable for therapy;
- * A failure to understand dependence as a chronic disease;
- * Long waiting lists, limited space and lack of resources and personnel in many prisons. There are not enough staff to deliver the treatment properly.

AOT is a way to attract the prisoner to the health unit, to stabilize them once they are there, and then to provide care and support through therapies (group and individual) and eventually achieve well-being without AOT.

On the other hand, agonist opioid treatment is seen as a cost factor and an additional organizational task.

Prisoners also demonstrate resistance due to:

- (i) a failure to understand the nature of agonist opioid treatment; prison sentences are often viewed as a drug-free period of time. Agonist opioid drugs are also seen in this context as hedonistic, psychoactive drugs (because they

can, alternatively, be purchased on the black market from dealers who sell other illegal drugs) and not as drugs that play an essential role in a medical treatment for drug dependence.

- (ii) prisoners want to hide their drug use (one reason being that they fear prejudice and disadvantageous treatment if they are seen as drug users); such use cannot be hidden if they are receiving treatment.

Even when they are in agonist opioid treatment, many prisoners want to reduce their dosage to zero shortly before release because they want to leave the prison 'drug free', either to avoid returning to a condition of dependence on the methadone-prescribing clinics once they are outside, or because they wish to avoid the drug scene around dispensing clinics. This kind of attitude exposes prisoners to enormous risks, because they overlook the serious dangers associated with relapses.

Prisoners want to hide their drug use for several reasons: one is that they fear prejudices and discrimination for their current sentences due to their being viewed and treated as a 'drug user' when taking part in an agonist opioid programme. That drug use would become immediately apparent if they spent time at a medical unit on a daily basis.

Initiation of agonist opioid treatment in prisons

There should be access to agonist opioid treatment for all prisoners who need it.

Bearing in mind the many reported experiences of immediate relapse after release, these prisoners should be given a choice between detoxification and maintenance.

Given the recurrent, longlasting dangers of substance dependence, detoxification alone is seldom effective in producing long-term change. The benefits of agonist opioid treatment 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, assessments and treatment of psychiatric co-morbidity and social problems;
- * Using contracts and counselling to reduce the use of additional drugs.

Initiation of treatment

- * Immediately on admission to prison; or
- * While the sentence is being served; or
- * A certain period of time before release, to avoid relapse and overdoses, which are the main problem in most countries; it is advisable to maintain a prisoner on a small stable dose until he or she is released.

There is, in any case, an extremely high risk for drug-using prisoners of having a relapse and/or taking an overdose shortly after release.

Overdoses on release and suicides in prisons were key elements in some countries in taking the decision to offer AOT in prisons.

Dosing and supervision of intake

Research indicated that the average substitute dose varied considerably in prisons (from 30 to 70 mg). In contrast to community practice, many 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.

Prisoner should know the dose they use unless that is not desired. The supervision of intake (as methadone in liquid form or in tablets) is organised in different ways, and performed either by nurses or guards, depending on how and where the agonist opioid drug is dispensed: either within the medical unit or in the cells/wards. This is to ensure that the substance is swallowed – a datum, which, in most cases, is checked by letting patients talk afterwards.

In some settings, the medication is dispensed by guards when the medical staff is not on duty.

Anonymity and confidentiality of treatment

Before getting any sort of treatment, every patient should know what main obligations a physician has to the State, to the prison where he or she works and to the prisoners.

Although it is hard to ensure anonymity and confidentiality in a prison context, attempts have been made to administer agonist opioid drugs in a way that protects prisoners, either by putting all patients together in one wing or delivering agonist opioid drugs discreetly, together with other pharmaceuticals. Exceptional cases were found in which prisoners complained of the public identification of those on treatment.

Prison is a different setting from an addiction clinic located outside; all that can be done is to bring the actual circumstances closer to the ideal situation.

Other inmates and staff should not be allowed to know that a prisoner is a drug user or in AOT treatment.

A prisoner should always have a right to complain, even on drug addiction treatment issues. It should be made very clear how complains are to be made.

Privileges

The right to privacy, as in the case of not letting everyone in the prison know that someone is using agonist opioid medication, can interfere with the way privileges, such as leaving prison for visits, or early release from the prison, are distributed. This is why many prisoners are reluctant to accept agonist opioid treatment; they feel that agonist opioid treatment will mean a loss of rights.

Users involvement

Ongoing contributions from patients are valuable in the search to improve the quality of health care; most prisoners have had previous personal experiences of health care and agonist opioid treatment while in prison and in the general community (during detoxification or maintenance).

The acknowledgement and integration of prisoner's experiences and expertise are critical in involving drug users in the developing, designing and delivering of information materials, because this is the most effective way of increasing their ap-

propriateness and scope.

Overdoses

Overdose is a leading cause of morbidity and mortality among active opiate injectors. Several studies have reported the high prevalence of both fatal and non-fatal overdosing among heroin injectors.

The likelihood of overdose rises when two or more drugs are consumed and their effects interact. This is usually observed when opioids, alcohol and benzodiazepines (or other sedatives) are taken concurrently.

People are at greater risk during the first few weeks after their release of prison.

Training

Besides what has already been stated, prisoners clearly have the right to receive state of the art medical care.

The need to establish good clinical practices in prisons, might be extended to the surrounding communities, as well.

In several countries, specific training for medical and guard staff is not required. This prevents professionals from responding to a fast-changing treatment environment and making the necessary improvements. In cases where most staff have to learn on the job, additional training would be welcome. It has been reported that some training programmes focus on drugs and drug treatment in the community, without any targeting of the prison setting.

Substantial improvements can be done by providing guidance and support in the following ways:

- Development of written materials such as treatment manuals and guidelines.
- Supporting further training initiatives.
- Providing support for the development of a treatment research network.
- Providing support for the further development and improvement of approaches to monitoring and evaluation.

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