

# Chapter 10 – Medical management of drug dependence in the context of criminal justice: illicit drug use, courts and prison

## 10.1 Introduction

The criminalisation of possession and supply of illicit drugs, and acquisitive crime associated with drug use, result in many illicit drug users being imprisoned. The maximum penalty is life imprisonment for supply of Class A drugs, with seven years for possession, but sentences between two and 14 years are used for possession or supply of Class B or C drugs (see **Chapter 1**). This has implications for the medical professional, as many illicit drug users first come into contact with the medical profession via the criminal justice system.<sup>1</sup>

The general principles of medical ethics apply to all individuals who come into contact with medical professionals through the criminal justice system.<sup>2</sup> This includes their right to confidentiality; the right to choose their own doctor (although this is not a right for convicted prisoners); the requirement for informed consent to medical treatment; the right to refuse treatment; and, for those detained or in prison, the right of access to the same treatments that are available outside the detention setting. This can create particular challenges for medical professionals working within the criminal justice setting, which are highlighted throughout this chapter.<sup>2</sup> These issues are discussed in a recent joint publication by the Royal College of General Practitioners, Royal Pharmaceutical Society and The Secure Environment Pharmacist Group, *Safer prescribing in prisons*.<sup>3</sup>

The controlled environment of prison is, nevertheless, more likely to ensure compliance with drug treatment programmes than is possible after discharge. It offers a valuable opportunity for effective medical treatment of drug use disorder and ultimately the best chance for many dependent drug users to be rehabilitated. This is illustrated by the case study that follows.

**Case study: Drug-related crime resulting in drug treatment in prison**

A young woman aged 19 years appeared in the Crown Court charged with a series of offences that she had committed while on bail granted in relation to other earlier offences. A report from the Probation Service explained that she had been picked up by police after having collapsed in the stairwell of a housing estate in east London. It also explained that she was homeless; she had been living in a local authority hostel but had been thrown out of it for taking men back into the hostel for the purpose of prostitution in order to raise funds to feed her drug habit. She was barely conscious at the time that she was found by the police and was high on drugs. She was due to be sentenced for a series of offences, which included attempted robberies of mobile phones from young women whom she had threatened with a knife, and attempts to snatch handbags, also from young women leaving a tube station late at night. All the attempts had failed.

The probation report explained that she committed these offences to raise funds to buy drugs and that she was so dependent that, unless she was taken off the streets (and in effect given a lengthy prison sentence), there was a real risk that she would die. She had two children. The oldest was a six-year-old girl, who had been taken away by the grandmother to Belgium (it was said that she had, in effect, abducted the granddaughter to save her from her mother) and she also had a two-year-old child who was in care.

After hearing evidence from the Probation Services, the court imposed a prison sentence at the maximum end of the scale for offences of that nature. The court discussed the possible range of sentences with defence and prosecution counsel and the discussion proceeded upon the basis that it was, in effect, common ground that, for her own good, she needed to be given a custodial sentence of the longest duration that was proper in the circumstances. This would give the defendant the best chance of receiving drug treatment in prison. The case was unusual in that the Probation Service was able to make enquiries about which prison the defendant would be sent to, and about the availability of drug treatment courses in that prison. This was exceptional, since it is very rare indeed for a sentencing judge to know anything about the prison to which a defendant is to be sent, or about the availability of drug rehabilitation courses in that prison.

Case study details provided by Nicholas Green QC, who has a special interest in the impact of drugs policy upon the administration of the justice system.

## 10.2 Drug use prior to, during and after incarceration

The prevalence of problem drug use among prisoners in the UK is high. While drug treatment programmes delivered in a controlled prison environment may offer some prisoners the opportunity to be rehabilitated, rates of drug use during incarceration remain high. A survey of nearly 1,500 new UK prisoners in 2005-2006 found lifetime use of heroin, crack cocaine, cocaine powder, amphetamines or cannabis was reported by 79 per cent of prisoners, with approximately one-third having used heroin or crack cocaine during the year before custody.<sup>4</sup> These figures mirrored findings from a 1997 National Survey of Prisoners in England and Wales,<sup>5</sup> showing high rates of drug use prior to and during incarceration. It has been estimated that up to half of all recorded crime is drug related.<sup>1</sup>

Rates of first initiation of use of drugs in prison are also high. Analysis of the findings of the 1997 National Survey found that over a quarter of the men who had used heroin reported first initiating use in prison.<sup>6</sup> A study across 13 prisons in England and Wales found that prisoners were also much more likely to continue to use heroin than either cocaine or amphetamines while in prison.<sup>7</sup>

### 10.2.1 The Drug Interventions Programme

The bidirectional links between drug use and offending have already been highlighted. The Drug Interventions Programme (DIP) was introduced by the Home Office in April 2003, with the aim of developing and integrating measures for directing adult drug-using offenders into drug treatment and thereby reducing offender behaviour.<sup>8</sup> The majority of DIP referrals into treatment are achieved via drug testing in police custody suites. The DIP also provides for interventions at other stages in the criminal justice process, such as during an initial bail hearing or sentencing. DIP also has links with treatment-related community sentencing and the provision of treatment in prison.

Each person entering the DIP is unique and their care needs and treatment will be tailored to them. Care planning is integral to the process; this is an agreed plan of action between the service user and the Criminal Justice Intervention Team worker, which involves setting goals based on the individual needs identified. This plan documents and enables routine review of the service user's needs, goals and progress across four key domains:

- drug and alcohol use
- physical and psychosocial health
- offending
- social functioning (including housing, employment and relationships).<sup>9</sup>

Research by the Home Office has found the DIP to be effective in reducing reoffending behaviour.<sup>8</sup> Each person completing a DIP had a care plan with medical treatment at one or four levels or tiers dependent upon their individual needs, for example, the nature of their drug use (frequency of use, and number and types of drugs used). The different levels/tiers of treatment reflected their intensity and ranged from non-specialist general healthcare through open drugs treatment and community-based drug treatment to residential drug treatment.<sup>8</sup> The overall volume of offending of a cohort of 7,727 individuals was 26 per cent lower following identification through a positive DIP test. Around half the cohort showed a decline in offending of around 79 per cent post DIP.<sup>8</sup> Earlier research by the Home Office, conducted before the introduction of DIP, lent support to the idea that drug-using offenders who are not directed towards treatment are unlikely to change in their pattern of drug use.<sup>10</sup>

### 10.2.2 Drug Rehabilitation Requirement

The Drug Rehabilitation Requirement (DRR) was introduced as a sentencing option under the Criminal Justice Act 2003. This requirement is one of a menu of 12 requirements to which offenders can be sentenced. The DRR involves drug treatment and testing and is a rehabilitative as opposed to a punitive requirement. The period of treatment can last between 6 months and 3 years. There are three levels of intensity of contact, which include, but do not entirely consist of, medical treatment. These levels correspond to the criteria of low, medium and high seriousness.

Before making the requirement, the court must be satisfied that:

- the offender is dependent on or has a propensity to use any controlled drug
- he or she would benefit from treatment
- the necessary arrangements can be made for the treatment
- the offender agrees to comply with the requirement.

Arrangements for treatment are available through the Probation Trusts, which operate at a local level. Several private or charitable organisations also work in partnership with the Probation Trusts/the National Probation Service to deliver DRR programmes and testing.

There is provision for the court to review the progress of the offender during the order, and to agree changes in the treatment.

The treatment can be residential or non-residential, which is decided by the court, and must be supervised by a suitably qualified person. The type of treatment and the treatment provider must be written in the order.

In 2009-2010 there was an 11 per cent decrease in the number of DRR commencements in England and Wales, while the completion rate increased from

47 per cent to 56 per cent.<sup>11</sup> The 11 per cent reduction was partly due to police initiatives which diverted offenders from charge, and a change in focus so that targets were more focused on completion and not commencement.<sup>11</sup>

Accessing treatment, however, can be problematic for drug users subject to a DRR. A review of the National Drug Rehabilitation Requirement found a variation in treatment delivery across England and Wales.<sup>12</sup> In some cases this was due to *'local service level agreements or communication protocols not being set up between probation and treatment agencies, so that only a minimum number of agencies were seen as "DRR friendly"'*.<sup>12</sup>

### 10.2.3 Drugs courts

Since 2004, six pilot Dedicated Drug Courts (DDCs) specialising in dealing with offenders who are illicit drug users were introduced in magistrates' courts in England and Wales. Building on existing arrangements available through the drug treatment and testing order and DRR, a pilot model for England was launched in 2005 in Leeds and London, while a further four pilots (in Barnsley, Bristol, Cardiff and Salford) opened in 2009.

The DDC pilots in England and Wales were aimed at reducing illicit drug use and reoffending amongst drug-using offenders who commit low-level crime to fund their addiction.<sup>8</sup> The DDC model introduced a new framework in magistrates' courts for dealing with such offenders. Sessions were set aside in existing magistrates' courts for dedicated panels of magistrates or particular district judges to sit for sentencing. A drug-using offender who was convicted of a low-level 'acquisitive' offence, for example shoplifting, could be referred to the DDC for sentencing.

Appropriate sanctions and other rehabilitation services that could be included in community sentences were available to all courts in England and Wales. The DRR included conditions such as: increasing the offender's likelihood of successful rehabilitation through early, continuous and intense judicially supervised treatment; mandatory periodic drug testing; and community supervision.

In January 2011, the Ministry of Justice published *The Dedicated Drug Courts Pilot Evaluation Process Study*.<sup>13</sup> The evaluation did not attempt to measure the actual impact of the DDC on reducing reoffending through decreased drug use. Instead, it focused on identifying the factors that may have had an impact on the effectiveness of the DDC, such as the structure of the court and the styles of engagement used by staff. The findings indicated that the DDC model was perceived to be a useful addition to the range of initiatives aimed at reducing drug use and offending.<sup>13</sup> Continuity of judiciary when working with drug-using offenders was seen to be a key element of the model: offenders reported that they felt accountable to the DDC through seeing the same

judicial panel and through the formal monitoring of drug use, and that this continuity helped to reduce drug use and offending.

### 10.2.4 Ethical issues

Referrals for treatment from police custody suites, as in the DIP, and the power of courts to 'sentence' an offender to receive medical treatment rather than a custodial sentence or other type of punishment raise concerns about informed consent to treatment. It also leads to a blurring of the distinction between judicial and therapeutic strategies, with the result that a drug user may view the doctor treating them as part of the judicial system and be confused about whether they are being punished, or treated as a patient. Effective communication is essential to ensure that those undergoing treatment fully understand their rights as outlined in **Section 10.1**.

Issues that arise for health professionals include the following:

- high rates of illiteracy and learning disability in offenders, often coupled with a lack of time and/or privacy for consultations, which raise serious questions about their freedom to give informed consent
- the perception of offenders that the doctor is not impartial but is working for the police or prison
- the ethics of providing treatment when the patient has effectively been coerced to consent.<sup>2</sup>

It should additionally be noted that:

- it is unlawful to give compulsory mental health treatment in a setting other than a hospital
- all patients are owed a duty of confidentiality but this is never an absolute duty
- when governors or managers need information in order to protect the safety of other detainees or patients, doctors must make decisions about whether to disclose health information in the public interest, on a case by case basis and, where disclosure is necessary, only the minimum amount of information should be shared.<sup>14</sup> People detained in police custody have a right to request examination by their own doctor, and individuals held on remand have a right to consult a doctor of their choice; convicted prisoners have no general freedom of choice regarding the doctor that they see.<sup>2</sup>

It is paramount to build up trust between the doctor and patient, and to reassure all patients that the doctor is impartial and not working for the judicial system.<sup>2</sup>

### 10.3 Reducing the supply of drugs entering prisons

Drugs are introduced into prisons through a variety of means,<sup>15</sup> including being smuggled into prisons with prison visitors, being projected or catapulted (quite literally) 'over the wall',<sup>15</sup> being hidden in items sent to prisoners in the post and in parcels, by prisoners themselves when they return from day release, and through corrupt staff.<sup>15</sup> The precise quantification of the problem is very difficult. It has been estimated that the value of illicit drugs within prison is about £100 million.<sup>15</sup> The incentive to supply drugs into prisons is exacerbated by the fact that the value of drugs in prison is greatly inflated relative to outside prices.<sup>15</sup> Controlling illicit supplies is very difficult; when the authorities succeed in curbing one supply route, this serves to increase supplies through other routes.

There is disagreement as to which of the routes of illicit supply is the most prominent. A report in 2008 by Blakey,<sup>16</sup> commissioned by the Director General of the National Offender Management Service (NOMS), did not differentiate between the frequency and extent of different routes of supply.<sup>a,15</sup> Recent analysis suggests that the major problem is staff corruption. A Policy Exchange report in 2010 contends that the majority of drug dealing within prison is highly organised and involves the collusion of around 1,000 corrupt staff, which equates to around seven prison officers per prison.<sup>b,15</sup> It is reported that they are able to introduce drugs into prisons due to lax security arrangements.<sup>15</sup> Given the inflated value of drugs in prison, it is suggested that prison officers are able to make substantial profits, effectively without fear of detection;<sup>c</sup> a prison officer bringing a gram of heroin into prison every week (about the size of two paracetamol tablets) could expect to more than double their basic salary.<sup>15</sup>

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a This was the essential criticism made of the Blakey Report<sup>16</sup> by the Policy Exchange Report;<sup>15</sup> see the latter report pages 14, 15, 21-5.

b The figure of 1,000 is based upon a 'leaked' internal Metropolitan Police investigation report conducted in 2006.

c Ministry of Justice data provided on 4 May 2011 (to a Channel 4 programme on illicit drug supplies in prison) indicates that between 2008 and 2011, 92 prison staff had been dismissed, 78 had been convicted and 167 staff who worked for other agencies within prisons had been excluded as a result of illicit drug supplies.

## 10.4 How effective are current treatment modalities?

It is important that medical professionals are able to make independent clinical and ethical decisions about the most appropriate treatment for individuals in prison, in exactly the same way as for those living in the community outside prison. It is also important to fulfil the requirement for informed consent to any treatment, including OST and opioid detoxification. This includes the right of patients to refuse any treatment offered.<sup>2</sup>

The Integrated Drug Treatment System (IDTS), jointly developed by the NOMS and the DH, aims to increase the volume and quality of drug treatment available in prisons, and the NOMS Drug Strategy 2008-2011 lists as one of its aims to '*Increase the access to and quality of drug interventions, matched to individual needs*'.<sup>17</sup> A national evaluation of the prison IDTS programme is now taking place, assessing post-release outcomes, including whether there are increased numbers of people remaining in treatment on release, and reduced offending.<sup>18</sup>

The effectiveness of MT (see **Chapter 8**) in prisons can be measured by key outcomes, including its impact on continued heroin use by those in treatment, continued levels of drug use in prisons, and the impact on drug-related harms, including blood-borne virus transmission and overdose (described in more detail in **Sections 10.5** and **10.6**). Treatment with methadone in prison has been shown to significantly reduce heroin use among those treated.<sup>19</sup> Lasting benefits of continued engagement with treatment services after release into the community have also been shown – those initiated in MT in prison in the USA have been shown to be significantly less likely to have urine drug screen results that are positive for either heroin or cocaine at 12 months after release.<sup>4,20</sup> A 4-year follow-up study after the initiation of MT in New South Wales, Australia showed that retention in MT was associated with reduced mortality, reduced reincarceration rates and reduced hepatitis C infection.<sup>19</sup>

## 10.5 Opioid detoxification in the prison setting

In 2005, the predominant method of clinically managing the majority of problem drug users in prison was detoxification (see **Chapter 8**),<sup>21</sup> while the following year, the IDTS sought to increase the available treatment options, akin to those available in community treatment settings.<sup>21</sup> As in the community, medical professionals managing opioid dependence in the prison setting must consider in each case the most appropriate treatment pathway or the individual's needs and circumstances. Treatment options will include continued opioid prescribing or slow reduction or detoxification if appropriate, with regular reviews, and clinical decisions based on a careful and full assessment, including risk assessment, in collaboration with the full team and the patient.

For those with shorter sentences, or soon to be released back into the community, an additional factor to consider is the reduced opioid tolerance following a break in opioid use, and the well-documented increased risk of drug-related death soon after release from prison.<sup>22,23</sup>

In addition to safety considerations (see **Section 8.6**), the medical professional will need to consider effectiveness. There is a paucity of research evaluating the most effective treatment for opiate detoxification in prisons. The Leeds Evaluation of Efficacy of Detoxification Study (LEEDS) Prisons Project Study, an RCT comparing methadone and buprenorphine for opiate detoxification, is currently under way,<sup>24</sup> and will help to provide an evidence base for medical professionals in considering detoxification care plans in the prison setting.

A randomised trial of the long-acting opioid antagonist oral naltrexone for treating opioid-dependent offenders after release from prison (6 months of either 300mg per week oral naltrexone plus standard psychosocial treatment as usual or standard psychosocial treatment as usual without naltrexone) in the USA reported large drop-out rates in both groups,<sup>25</sup> emphasising the limitations of giving oral naltrexone without supervision. A study in which prison volunteers were randomly allocated to naltrexone implants or methadone before release showed reductions in both groups in the frequency of use of heroin and benzodiazepines, as well as criminality, six months after prison release.<sup>26</sup> With the emphasis on patient choice and safety, clinicians may consider the option of naltrexone in their discussions around opioid detoxification with prison patients.

## 10.6 Reducing blood-borne virus transmission

It is important that detainees have full access to information about transmissible diseases, including TB, hepatitis and HIV; an ethical requirement is that they have the same access as those outside prison to harm-reduction measures and treatment.<sup>2</sup>

As emphasised in **Section 8.3.4**, OST reduces the risk of transmission of blood-borne viruses (HCV and HIV), particularly in conjunction with the availability of clean needles, syringes and other injecting paraphernalia.<sup>27,28</sup>

Opioid substitution has been found to play an important role in reducing the transmission of HIV in the prison setting.<sup>29</sup> The high prevalence of problem drug use by the prison population<sup>4,5</sup> is accompanied by high rates of blood-borne viruses. In one meta-analysis, the pooled odds ratio of being positive for HCV was 24 times higher among inmates who were currently or formerly using drugs intravenously, compared with inmates who were not doing so.<sup>30</sup> Rotily et al found the HIV prevalence among users of intravenous drugs was 4 per cent (versus 1% among those not injecting drugs intravenously).<sup>31</sup>

### 10.6.1 Needle exchange

A cross-sectional survey carried out in six European prisons (including in Scotland), found that 27 per cent of respondents had ever injected drugs and 49 per cent of these reported they had injected while in prison.<sup>31</sup> Stark et al assessed the impact of a needle-exchange programme in a prison in Berlin.<sup>32</sup> They found baseline seroprevalences for HIV, HBV and HCV of 18, 53 and 82 per cent, respectively, among the prisoners. The seroprevalence of HIV and HCV at baseline was significantly associated with drug injection in prison prior to the introduction of a needle-exchange facility.<sup>32</sup> The provision of needle-exchange facilities was linked to a decrease in syringe sharing from 71 per cent during a 4-month period of previous imprisonment to 11 per cent during the first 4 months of follow-up, and to virtually zero thereafter. No HIV and HBV seroconversions occurred during the study period after the introduction of the needle-exchange facility, although four HCV seroconversions occurred.<sup>32</sup> (Although not the focus of this chapter, this emphasises the importance of also involving other coordinated approaches in the prevention of blood-borne virus transmission, such as the provision of condoms and sterile tattooing equipment.)

For those who use drugs intravenously, the provision of needle- and syringe-exchange facilities in the prison setting is an important harm-reduction measure, just as it is in the community (see **Chapter 9**). The provision of such needle-exchange programmes in prisons is part of the guidance from the WHO, the UNODC and the Joint United Nations Programme on HIV/AIDs (UNAIDS).<sup>33</sup> Proposals for such programmes in prisons have also been met with concerns about staff safety.<sup>34</sup> The 2011 DH document *Tackling blood-borne viruses in prisons: a framework for best practice in the UK* comments, 'nowhere in the UK currently offers needle exchange to prisoners'.<sup>35</sup>

In Scotland, plans to pilot an in-prison injecting equipment initiative in the Scottish Prison Service as one of a range of harm-reduction measures to reduce the transmission of HCV were raised in the *Hepatitis C Action Plan for Scotland Phase II: May 2008-March 2011*.<sup>36</sup> The Scottish Prison Service also carried out its own review of the literature on prison-based injecting equipment provision (IEP) services in 2005. They reported on 46 prisons in four European countries with IEP schemes in operation for around 10 years, and found that these schemes resulted in lower transmission rates of HIV and HCV, and no increase in drug use or injecting among prisoners. They also noted that, since the introduction of the schemes, there had been no attacks on staff or other prisoners with injecting equipment.<sup>37,38</sup>

## 10.6.2 Hepatitis B vaccination

Screening and vaccination can reduce the likelihood of infection and transmission, and therefore need to be considered along with harm-reduction strategies.

The overall improvement in uptake of the HBV vaccine probably reflects improved provision through drug services and the prison vaccination programmes.<sup>39-41</sup>

There has been a marked increase in the number of injecting drug users receiving the hepatitis B vaccine, with over two-thirds now reporting vaccination.<sup>41</sup> In 2009, 80,762 doses of hepatitis B vaccine were reported to have been delivered to prisoners in England and Wales.<sup>42</sup> Medical professionals play an educative role in ensuring that staff and prisoners are aware of the importance of HBV vaccination in the prison setting.

## 10.7 'Drug-free' wings

According to its 2008-2011 strategy, the NOMS will aim '*within existing resources, subject to a detailed needs assessment, to offer to every prisoner who wants to make the commitment to lead drug-free lives, access to accommodation designated as drug-free*', also offering engagement in prison treatment, and interventions such as the 12-step programme (see **Section 9.5.2**).<sup>17</sup>

## 10.8 Reducing drug-related deaths in custody and after release

Some authors warn against the risks of death from methadone prescribing in the prison setting, in particular where the same dose is prescribed as that reportedly used in the community, where it may not have been consumed under supervised conditions, and some may have been diverted over a period of time, so the tolerance of the patient may be far lower than assumed.<sup>43</sup> There is evidence that '*...in the past patients have died as a consequence of uncontrolled vomiting during detoxification in prison*',<sup>21</sup> so careful assessment is essential.

The 2006 DH report on the clinical management of drug dependence in the adult prison setting makes recommendations to reduce this risk,<sup>20</sup> which include the following:

- clinical drug testing to include morphine, methadone and buprenorphine
- use of an opioid withdrawal assessment scale (eg short opiate withdrawal scale,<sup>44</sup> and intoxication monitoring)
- ensure the patient is fully alert, responding appropriately and that there are no signs of drowsiness/sedation; withhold medication in the event of any concern
- gradual dose induction, with divided doses
- a minimum of twice-daily monitoring of withdrawal and intoxication during stabilisation
- staff training in the administration of naloxone.<sup>21</sup>

The role of the medical professional includes careful assessment and careful prescribing, taking into account the unknown tolerance of the patient whose medication may not have been supervised in the community, and the possibility of polydrug use increasing their risk of overdose, balanced against the importance of engagement of the patient and minimising their seeking to engage with illicit drug use in prison.

The information in **Section 8.6.1** on reducing drug-related deaths at times of increased risk is particularly relevant for individuals who are newly released from prison. Prevention of relapse is discussed in **Section 9.5**.

## **10.9 Seamless transfer to community services from prison release**

A meta-analysis of drug-related deaths soon after release from prison confirmed that there is an increased risk during the first 2-4 weeks after release from prison,<sup>26</sup> as found by other authors.<sup>19</sup> Drug-related deaths among men were more likely to involve heroin, and deaths among women were more likely to involve benzodiazepines, cocaine and tricyclic antidepressants.<sup>22</sup> The increased risk of drug-related death soon after release from prison is well documented.<sup>22,45</sup> A database linkage study covering 48,771 prisoners found that, relative to the general population, male prisoners were 29 times more likely to die during the week following release, while female prisoners were 69 times more likely to die during this period, with the prime cause of death being overdose of heroin or other opioids.<sup>22</sup>

Authors have highlighted the importance of ensuring that drug-dependent prisoners are linked with community drug services on release from prison,<sup>46,47</sup> and the DH gives guidance in this, including the role of CARAT (counselling, assessment, referral, advice and throughcare) workers in directly linking the patient with community clinical teams.<sup>21</sup> In cases where the patient-prisoner is being released late on a Friday and it has not been possible to link them directly with a pharmacist (although most pharmacists are also available for contact on Saturdays) or community drug service, the medical professional may play a role in carrying out a risk assessment in terms of the doses to be prescribed and taken home during the period before the patient will be reviewed in the community.<sup>21</sup>

## 10.10 Take-home naloxone

As described in **Chapter 8**, overdose in heroin users is common and is a particular risk with involuntary abstinence, as may occur in the prison setting.<sup>48,49</sup>

Strategies to reduce mortality rates from opioid overdose are described in detail in **Chapter 8**. A national programme of naloxone provision and training recently rolled out in Scotland for those deemed to be at risk of opioid overdose (and their family, friends, carers, and partners) includes prisoners who use opioid drugs on release from prison.<sup>50</sup> In England, a large randomised trial is currently under way,<sup>51</sup> in which naloxone is given on release to prisoners with a history of heroin use by injection. It is hypothesised that this will reduce heroin overdose deaths in the first 12 weeks after release by 28 per cent.

## 10.11 Promoting recovery after release from prison

While social integration is an important part of the purpose and function of prison, in many cases,<sup>52</sup> for those with drug dependence, the challenge of social reintegration, of moving away from drug use and to '*personal health and citizenship*'<sup>53</sup> continues after prison release. Liaison with community teams is essential at this crucial stage. In a primary care clinic setting, MT is effective in reducing convictions, cautions and incarceration over an extended period.<sup>54</sup> A study of 382 imprisoned male heroin users who had participated in an RCT of prison-based MT in 1997-1998 followed up subjects over a 4-year period, either in the general community or in prison, and found, among other benefits, that the risk of reincarceration was lowest during MT episodes of 8 months or longer.<sup>19</sup> A key role that treatment of drug use and drug dependence can play in promoting social reintegration is by reducing the likelihood of reincarceration. Recovery is about much more than avoiding harms, and while there is still debate about its definition,<sup>55</sup> it is generally agreed to be about positive elements – positive development, achieving potential, contributing to the social milieu, and accessing and benefiting from the rights of that shared society. Recovery capital has been described as the '*breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery*' from substance use.<sup>56</sup> Medical professionals are an essential external resource, who may also help the patient identify some of their internal resources and access other external resources to utilise these, in their recovery journey.

## 10.12 Research, training and resource needs

### 10.12.1 Research needs

As discussed in this chapter, there are many gaps in evidence on the treatment of drug dependence in the prison setting. Robust research evidence is particularly required in the following areas:

- study of the impact of drug rehabilitation availability on drug-related harms in the prison setting and after release, including drug-related deaths after release
- study of the impact of drug rehabilitation in prisons on decreased recidivism and social reintegration
- continued work on improving systems for prompt and accurate communication with community services pre and post incarceration, with a view to limiting overdose in custody and after prison release
- study of the impact of increased treatment choices on the demand for and availability of illicit drugs in prisons and/or in the rates of initiation of drug use in prisons and the rates of relapse in prison of those in MT or post detoxification
- audit of the provision of HBV vaccination programmes and needle-exchange facilities in high-risk environments, including prisons.

### 10.12.2 Training needs

Medical professionals have an important role in day-to-day communication with non-medical colleagues in the prison setting, to enhance their understanding of issues in the management of problem drug users. They also have an important role in educating patients in the prison setting about reducing risks associated with drug use. In addition to the needs identified at the end of **Chapter 8**, training needs include:

- training on the beneficial impacts of harm reduction on increasing treatment choices, including opioid maintenance treatment
- training for all staff in recognising opioid and other drug overdose in custody and in the prison setting, and training in how to respond to this, including contacting emergency medical services and administration of naloxone
- training for prisoners in overdose recognition and use of naloxone
- training in the importance of needle exchange in reducing blood-borne virus transmission and the importance of HBV vaccination in this population.

### 10.12.3 Resource needs

The needs identified at the end of **Chapter 8** are relevant here. Optimising the response of hospitals to drug problems requires the presence of consultation-liaison services to support staff in the management of withdrawal. This is particularly important for the prison population and for those newly released from prison.

## Summary

- Many illicit drug users first present to medical practitioners via the criminal justice system.
- Treatment of illicit drug users creates particular ethical challenges for medical professionals, especially in relation to coercion and informed consent within the criminal justice system. It is essential to recognise that these individuals have the same rights to accept or refuse treatment as the rest of the population.
- There is a high prevalence of drug use among prisoners in the UK, and high rates of first initiation of drug use.
- The Drug Interventions Programme (DIP), introduced by the Home Office in 2003, aims to develop and integrate measures for directing adult offenders who are illicit drug users into drug treatment and thereby reduce offender behaviour. Most DIP referrals into treatment are achieved via drug testing in police custody suites. This raises ethical issues about coercion to treatment.
- Methadone treatment in prisons has been shown to significantly reduce heroin use among those treated; retention in treatment is associated with reduced mortality, reincarceration and hepatitis C infection. It is hoped that a research study currently in progress in the UK will provide evidence about the most effective treatment for detoxification in prisons. Naltrexone may have a role in this treatment.
- Safety considerations are paramount in opioid detoxification treatment, especially in those soon to be released.
- Opioid substitution therapy has been shown to have an important role in reducing transmission of HIV in the prison setting.
- Needle-exchange programmes are important for harm reduction and are recommended for all illicit drug users in prisons in guidance from the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Nowhere in the UK offers such programmes in the prison setting.
- Vaccination for hepatitis B in the prison setting is important but not yet offered in every prison in England and Wales.
- The National Offender Management Service (NOMS) aims to offer all prisoners who want to commit to leading a drug-free life access to accommodation designated as 'drug-free'.
- There is a high risk of drug-related deaths in prison and shortly after release. Medical management must take this into account in planning treatment.
- It is important to ensure patients are linked with community drug services immediately on release from prison.
- The use of naloxone may reduce mortality from drug overdose.

