Methadone in prisons: Route to recovery or chemical cosh?

Neil McKeganey, Mark Johnson, Marcus Roberts and **Michael Wheatley** debate the thorny issue of providing drugs to people in prison.

Neil McKeganey: 'Methadone must be used judiciously'

Providing dependent drug users a highly addictive drug is always going to be a risky business and for that reason it requires tight guidelines as to how much and for how long the drugs should be made available. That is very much the issue behind the provision of methadone to prisoners. There is no doubt that methadone can and does have a beneficial role to play in facilitating addicts recovery however methadone must be used judiciously and only prescribed to prisoners where there are clear therapeutic benefits for the individual concerned. Where those benefits cease then there is a clear need to ensure that the prescribing of methadone to the individual also ceases. It is also important to ensure that where methadone is being prescribed to prisoners that it is part of a programme focussed upon the individual's recovery. Methadone should not be used as a life long substitute medication for dependent drug users whether they are within prison or resident within the community.

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But should methadone be used as widely in prison as it is within the community? It is often stated that drug users in prison should have access to the same treatments as are available within the community. But to what extent is such a view appropriate. Research carried out on methadone has shown that prescribing the drug to a dependent drug user can result in an improvement in the individual's life evident in reduced criminality reduced use of illicit drugs greater stability in the individual's life lower levels of HIV related risk behaviour and reduced risk of experiencing a fatal drug overdose. Individually and cumulatively these are substantial benefits however they are also benefits that are associated with being resident within the prison environment e.g. where there are lower levels of drug use and criminality within the prison than within the community, lower levels of needle and syringe sharing fewer overdoses where drug using inmates receive regular means and where they are preferably engaged in some level of meaningful employment. It could be said then that the benefits of prescribing methadone within the community are less evident within the prison where those selfsame benefits are themselves part of the prison regime. This is not of course a reason not to provide methadone to prisoners where this is appropriate however it is part of the reason why when methadone is being prescribed to dependent drug using prisoners it is part of a prescribing regime that is aiming to enable the addict to become drug free. Prisons are one of the few places where addicts may rapidly experience the benefits of coming off drugs rather than staying on drugs and it is important to ensure that recovery to abstinence is the goal of all addictions treatment within prisons.

More recently prison medical staff have received guidance from the Department of Health to the effect that where prisoners are on a sentence of longer than six months duration, and are being prescribed methadone, this should be a decreasing dosage leading towards abstinence. The issuing of that guidance is a clear recognition that methadone prescribing within prisons has become too liberal. Addicted prisoners, as much as addicts in the community, require treatment services to help them become drug free since it is only in overcoming their addiction that they stand the greatest chance of building or rebuilding a life for themselves where they can make a fully positive contribution to society, to their community and to their family. ■

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Mark Johnson: 'Addicts entering jail are denied the chance of breaking their habit with a period of abstinence.'

I believe methadone can be both a useful tool and a cosh. Unfortunately, it's usually a cosh. Prisons should be places of rehabilitation but there's seldom an agenda to make them more than huge human warehouses. The sad, shuffling line of prisoners outside the dispensary waiting for their methadone ensures the smooth-running of the warehouse and quiet shifts for the staff. It doesn't help the drug user. It's obvious that a person made sick by drugs should stop taking them. The government settled out of court with offenders who said that taking away their heroin contravened their human rights. By settling in this way ithe government allowed this *canard* to be re-interpreted as a truth. But methadone is the opposite of a human right. No one ever died through not taking heroin. The human rights abuse is that addicts entering jail are denied the chance of breaking their habit with a period of abstinence.

Methadone doesn't stop addiction, it simply provides a few more rocky ledges as the addict plummets down through the icy depths to the ocean's floor.

A prison term takes addicts away from their chaotic lives and established drug-using patterns and many would welcome such an opportunity to recover from addiction. But detox is a demanding process not only for the addict but for staff: during it the underlying emotional causes of the addiction surface and threaten to overwhelm both the recovering addict and those around him. High levels of appropriate and trained staffing are essential, as well as a commitment to the therapy which supports abstinence programmes. It's easier to write out a prescription and, if you're very short-sighted, you could delude yourself that it's cheaper too.

Let's not leave out the powerful role of the drug companies in those profitable methadone prescriptions. An analogy is the Government's attempt to cut cigarette smoking. The value of nicotine replacement therapy is open to challenge but instead of promoting ways to stop smoking altogether we are bombarded with expensive alternatives to cigarettes. Methadone doesn't stop addiction, it simply provides a few more rocky ledges as the addict plummets down through the icy depths to the ocean's floor. The methadone programme is lazy. It panders to our curious obsession with preventing death without championing a more demanding but rewarding goal: successful, abstinent living. ■

Mark Johnson, Uservoice.

Marcus Roberts: 'Substitute drugs should not be used in isolation as a form of chemical warehousing'

A comment piece in *The Times* in December 2009 caricatured methadone prescribing in our jails as 'hand[ing] out opiates willy-nilly'. The debate about the prescription of substitute drugs even intruded into the first Leader's debate of the General Election. David Cameron claimed that too many 'drug addicts' in treatment 'got put on a substitute drug'. This, he complained, was 'not really dealing with the problem … to get these people to confront their problems and lead drug-free lives'.

In 2009 DrugScope published the report Drug *Treatment at the Crossroads*. A key message was that a polarised debate about drug treatment was unhelpful. As one contributor argued: 'So is the aim abstinence? Yes. Is it maintenance? Yes. Do we need harm reduction? Yes. Is prevention important? Yes. There is no right or wrong answer .. there is no "one size fits all" solution to the problems people who use drugs face'.

Methadone is recommended by the National Institute for Clinical Excellence, because there is a substantial evidence-base that it delivers benefits to individuals, families and communities. At the same time, prisoners with drug problems typically have other problems that sustain addiction, such as mental health issues, experience of abuse or neglect and low educational attainment. Substitute drugs (or detox) have little direct impact on these problems. They should provide a base camp for recovery, allowing other interventions to take affect, and should not be used in isolation as a form of chemical warehousing.

Many prisoners are serving sentences that are too short for structured drug treatment programmes. Being moved around the prison system doesn't help either. Critics of prison drug treatment should also be arguing for better use of community sentences and less use of prison, which tend to compound many of the problems associated with drug dependency, such as homelessness and unemployment. We also need more integrated offender management so work begun in prison can be picked up in the community on release. Recovery from drug dependency is more often a long and winding road than one bound and you're free. ■

Dr Marcus Roberts is Director of Policy and Membership at DrugScope.

Michael Wheatley: 'Methadone in prison settings helps to get prisoners off drugs'

Many offenders enter prison with high levels of reported drug and/or alcohol problems and a large proportion are dependent on either heroin or cocaine.

Historically the Prison Service's response to drug dependency was inconsistent. With the introduction of the Integrated Drug Treatment Service (IDTS) in 2006 a transformation occurred. IDTS aimed to reduce drug dependency by offering consistent, focused, evidence-based treatment using pharmacological and/or psychosocial interventions. Since the introduction of IDTS, there has been a marked increase in the use of methadone in prisons as a pharmacological intervention. This means more prisoners are getting an evidence based treatment intervention to address their needs. However the Prison Service has now been criticized for using methadone as a 'chemical cosh'. The media suggest prison Governors and health professionals are trying to subdue and control inmates so they are less likely to cause trouble because the prison population has reached record levels. Is there any justification for this criticism?

I believe these accusations are untrue. Prisons aim to support the delivery of the 2008 national drug strategy that states, *'The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency.'*

Methadone is prescribed to those dependent on opiates as part of a recovery treatment to help offenders 'get off' and 'stay off' drugs (abstinence) thereby reducing crime and promoting health and well-being. There is evidence that prescribing methadone in prison settings helps to get prisoners off drugs, which can reduce reoffending and risky behaviours such as injecting, where agreed clinical guidelines are followed.

In March 2010, The Department of Health, supported by the Ministry of Justice, has issued updated guidance for prison based opiate maintenance prescribing. The guidance suggests that prisoners should not remain on open-ended maintenance regimes when detoxification or gradual reduction tailored to the individual's needs would be the more appropriate option. Many opiate users, particularly those on longer sentences, should be encouraged and supported to use their time in prison as an opportunity to achieve abstinence and this option should be discussed and facilitated. The guidance states that prisoners should be made aware that where a prison sentence of more than six months is received they will be expected to work towards becoming drug free. Extended periods of prescribing will occur only when there is compelling evidence to do so following a review which occurs at a minimum of every three months. This review should include input from the prisoner, prescriber and other members of the clinical substance misuse team, CARATs (Counselling, Assessment, Referral, Advice and Throughcare) team and/or offender supervisor.

When these guidelines are not applied the prisoner's journey towards recovery is often impeded. When this occurs, this is not a deliberate attempt to subdue and control prisoners but rather the by-product of the challenges of introducing an ambitious service to engage prisoners in drug free lifestyles, through specifically tailored interventions matched to individual needs, via better managed highly focused treatment programmes. Updated guidance, more training and closer monitoring of prescribing practices will help clinicians overcome these challenges and restore prisoners on the pathway to recovery as intended. ■

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