

Service user views on Opioid Substitute Treatment in Prison and on Release

Introduction

This report summarises a research study conducted by Russell Webster in Spring 2017 on the experiences of opiate using offenders seeking substitute prescribing (methadone or buprenorphine) in prison and on release. Interestingly, these service users had a wide range of experiences from proactive and prompt OST provision all the way through to an inability to access any substitute medication. The research was supported by an educational grant from Martindale Pharma¹.

Methods

The research utilised two main methods to gain service user views. First, an online survey was completed by 102 opiate users who had been in an English or Welsh prison in the last two years. Opiate using prisoners were identified and recruited by 10 peer researchers trained, supervised and supported by the Revolving Doors Agency. These researchers are based throughout England and Wales and each was set a target of recruiting 10 survey respondents². The survey asked whether respondents wanted and were able to access OST in prison and on release and how easy or not this access was. They were also asked to suggest improvements to current provision.

Analysis of the survey data informed the second stage of the research study; a focus group with nine individuals with recent experience of OST in prison. The focus group was convened by the Revolving Doors Agency and was held in Wolverhampton on 10 May 2017.

Demographic profile of service users

The survey was successful in accessing opiate users with recent experience of imprisonment. Ninety eight of the 102 respondents were active opiate users when they were last sent to prison. Ten respondents were in prison in 2017; 59 in 2016 and 27 in 2015³. Seventy nine (81%) survey respondents were men, 17 (18%) women and one transgender⁴;

¹ Martindale Pharma had no input into the design of the research, nor the analysis and publication of the results.

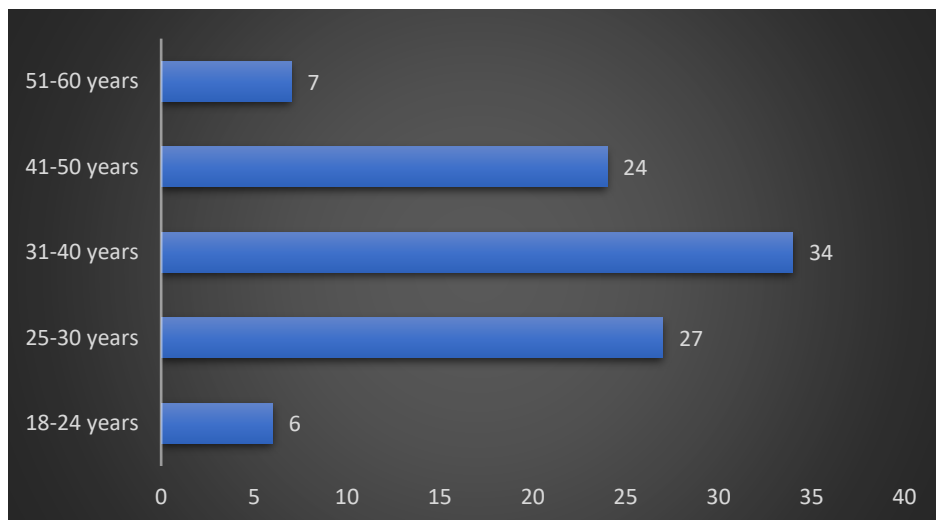
² Peer researchers received a payment of £100 each for recruiting survey respondents.

³ 96 respondents answered this question.

⁴ 97 respondents answered this question.

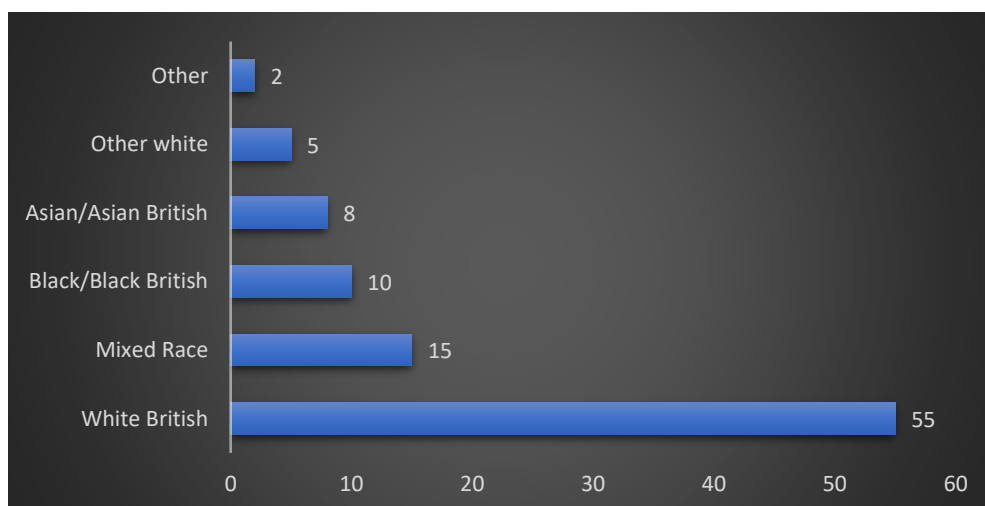
this is broadly representative of the prison population⁵. Two thirds (65/98 = 66%) respondents were aged between 31years old or older; a full breakdown is shown below:

Figure 1 Age of Respondents (n = 98)



Respondents were from a wide range of ethnic backgrounds with just over half (55/95 = 58%) from a white British background compared to nearly three-quarters (74%) of the overall prison population⁶. A full breakdown is shown below:

Figure 2 Ethnic background of Respondents



⁵ Approximately 5% of the prison population are women. Source: Prison Reform Trust (2016) Bromley Briefings Prison Factfile.

However, 41% women stated that they had a drug problem when they came into prison, compared to 27% men. Source: HMI Prisons (2015) Changing patterns of substance misuse in adult prisons and service responses.

⁶ 26% of the prison population, 22,236 people, are from a minority ethnic group. Source: Bromley Briefing op cit.

The nine individuals who participated in the focus group interview all had experience of accessing OST in prison; seven of them within the previous 18 months. All focus group participants were men; seven were white British, one Black British and one Black Asian. They all lived in the East and West Midlands.

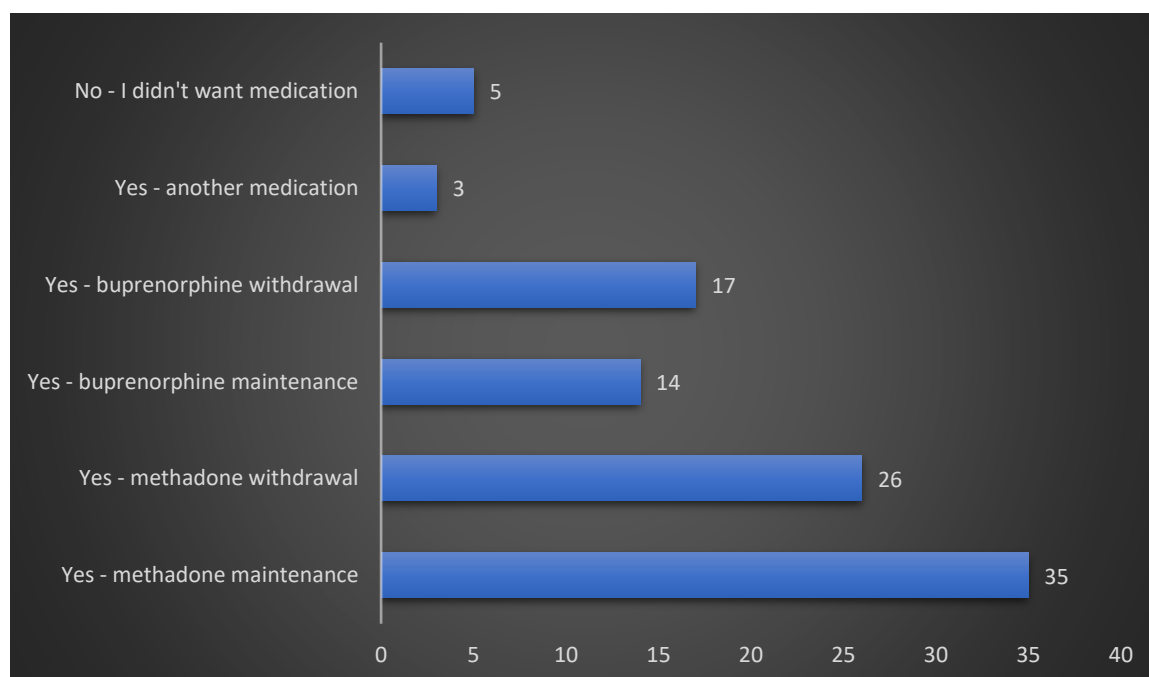
The experiences of survey respondents

Desired medication...

Survey respondents were first asked whether they wanted medication for their opiate dependency; whether they wanted methadone or buprenorphine and whether they wanted to be on a maintenance or reducing prescription.

As can be seen from the chart below; 95% of respondents did want medication, with a majority wanting a maintenance prescription and a majority also preferring methadone to buprenorphine.

Figure 3 Did you want medication? (n = 99)



The respondents who did not want methadone or buprenorphine stated they wanted dihydrocodeine and benzodiazepine (“DFs and sleepers”).

A number of respondents provided additional information with several saying that they were already being prescribed opiate substitutes on receptions to prison:

- Fourteen said they were being prescribed methadone in the community

- Three said they were being prescribed buprenorphine
- Three individuals also said that they wanted to use imprisonment as an opportunity to get off drugs.

...Medication accessed

Respondents were then asked: “If you wanted medication, did you get it?” and were given a choice of five options which reflected ease of access:

1. Yes – I was offered medication
2. Yes – I asked for medication and got it easily
3. Yes – I asked for medication and had to work hard to get it
4. Yes – I got some medication, but not what (or as much) as I wanted
5. No (I did not get medication)

The vast majority (88/94 = 94%) respondents did receive at least some medication with varying degrees of ease of access as shown in Figure 4 below:

Figure 4 If you wanted medication, did you get it? (n = 94)

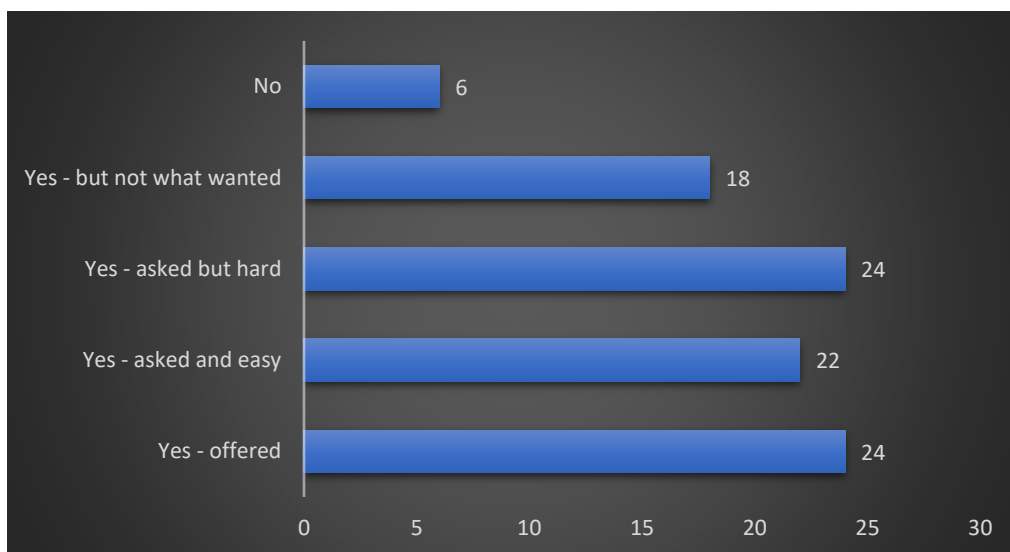
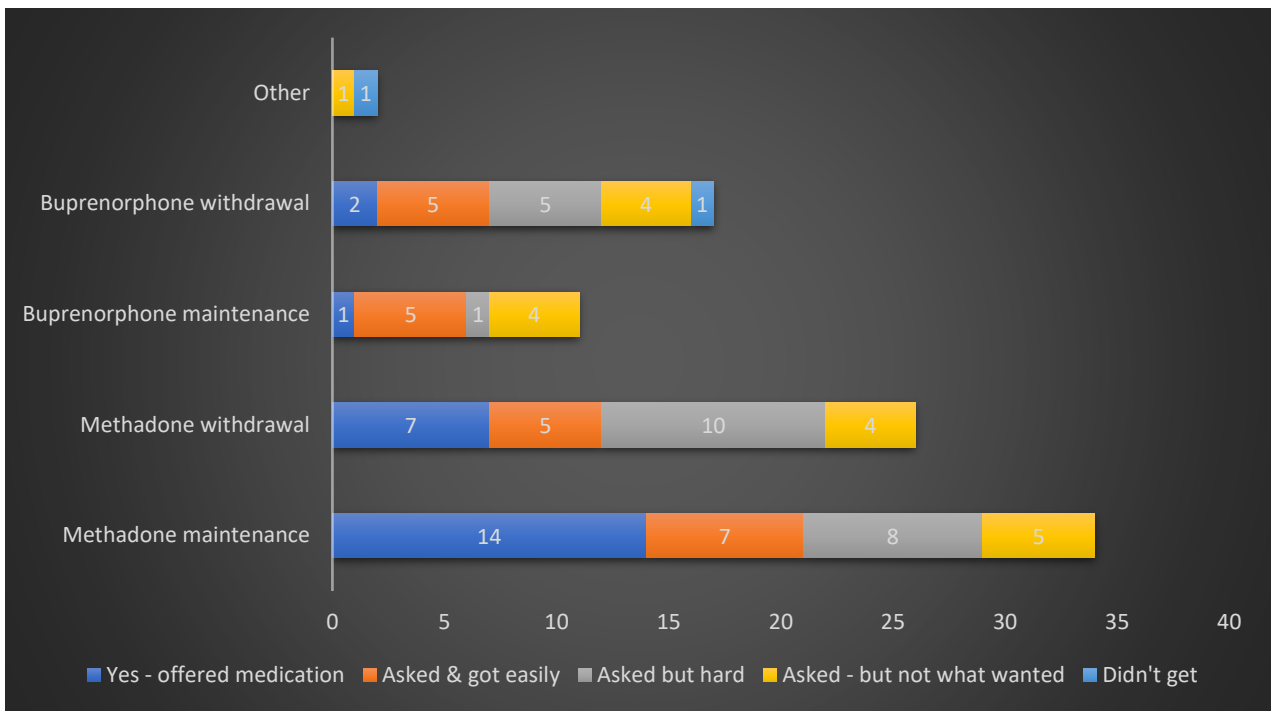


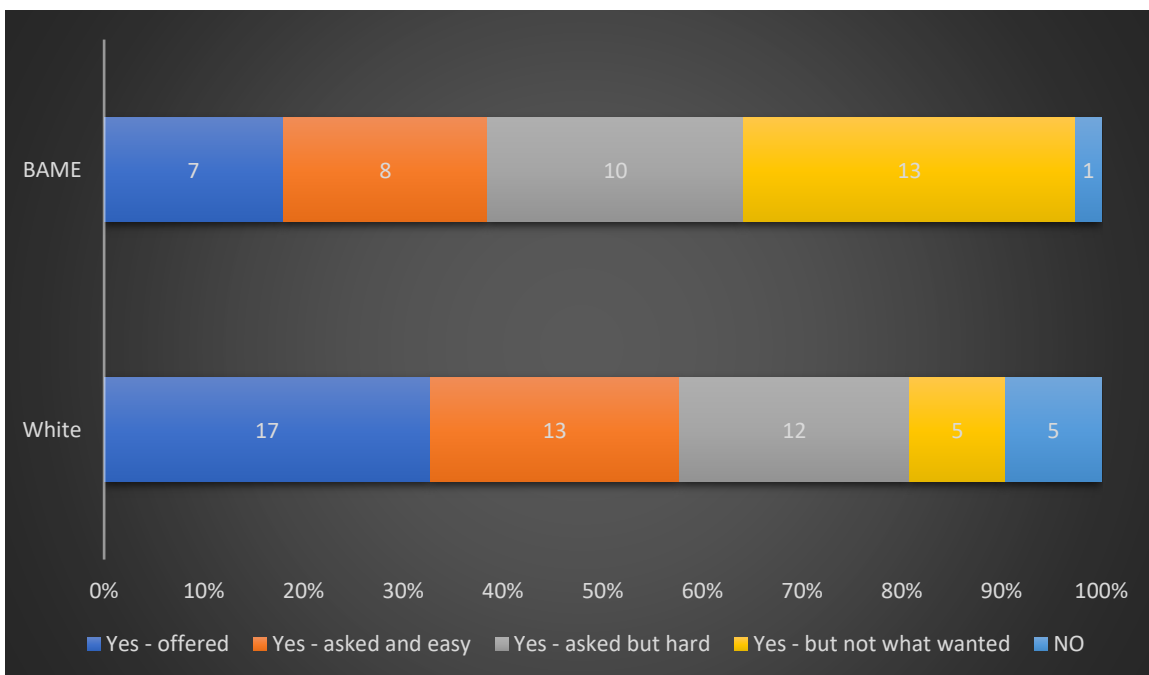
Figure 5 provides a breakdown of access to medication by substance where it can be seen that respondents found it much easier to access methadone with over half (33/60 = 55%) getting what they wanted easily and a large majority (51/60 = 85%) achieving their goal, if sometimes after a lengthy battle. This compares with less than half (13/28 = 46%) of those wanting buprenorphine getting what they wanted easily and almost one third (9/28 = 32%) not achieving their goal.

Figure 5 Ease of access to OST by substance (n = 94)



It was easier for white respondents to access the medication they desired than for respondents from Black and Minority Ethnic backgrounds. Almost three fifths (30/52 = 58%) white people were either offered medication or asked for it and got it easily. Over three fifths (24/39 = 62%) of BAME respondents either had to fight hard to get medication, did not get what they wanted or did not get any medication.

Figure 6 Ease of access to OST by ethnicity (n = 91)



Seventy five respondents provided extra information about the process of accessing OST. Experiences differed markedly; twelve respondents complained about the length of time it took to get a prescription while seven individuals said the process was fast and in two cases faster than it would have been in the community. Four of these seven individuals said that the process was fast because the prison already had records of their dependence either from recent previous imprisonment or from probation reports.

Respondents were not always able to get their substance of choice; seven individuals said they wanted buprenorphine (mainly because they were already or had recently been prescribed it) but were given methadone instead. Conversely, four respondents asked for methadone but were given buprenorphine.

Nine respondents stated they were given a lower (frequently half the) dose of methadone than they were being prescribed in the community and three said that there was pressure to detox rapidly.

Three respondents stated that because they were either not given substitute medication or only received it after a long delay, they self-medicated using either synthetic cannabinoids (two individuals) or heroin (1).

These issues were discussed with focus group participants who also had a range of experiences. The main common themes are set out below:

Access to some form of OST in prison was often better than in the community. However, there was rarely any user choice about either substance or whether OST was prescribed on a maintenance or withdrawal basis. There was a common experience that anyone serving a sentence of longer than three months (equating to 6 weeks in custody) would be placed on a withdrawal prescription.

Several participants were unable to access medication on their first day in prison, especially if they arrived late in the day. One person in this situation, already in the early stages of withdrawal, was promised medication by a nurse. When he requested the medication from a prison officer later the same evening, he was told none had been prescribed. When he followed up with the same nurse the next day, it transpired that methadone had been prescribed but that the prison officer was unwilling to give it to the prisoner.

Another individual who had been using very high levels of opiates in the community was refused OST and only given low doses of benziazepines throughout his 6 week sentence.

Several individuals reported that even when existing prescriptions were confirmed with a community physician, these were regarded as an initial bargaining position by prison prescribers who typically halved dosages of medications including opioid substitutes and benzodiazepines.

Several individuals talked about the prescribing process as being like a factory production line with no consideration of their emotional or psychological needs and a focus on prescribing minimal levels of opioid substitutes. Details of prescribing regimes were often not shared and several individuals reported going to collect their daily medication only to be told their prescription had ended,

Many participants shared the view that prescribers were increasingly reluctant to prescribe certain medications because of their diversion and re-sale. This applied particularly to gabapentin and buphenorphine and, to a lesser extent, methadone.

One large local prison had stopped prescribing buphenorphine, even for people on pre-existing prescriptions. In these cases, prisoners reported being given a rapid 7-day withdrawal and then prescribed 10 mls methadone daily.

Focus group participants also discussed a range of ways in which prisons were trying to prevent the diversion of medication.

In one prison, people prescribed buphenorphine were asked to drink water before their medication, then after medication, then to use mouth-wash and, finally, be subjected to a mouth-search by a prison officer. In another prison, buphenorphine was prescribed in a net bag which had to be returned to the nurse empty to prove that the medication had not been “cheeked”.

A number of techniques for secreting methadone were reported including diverting it into a plastic bag held in the mouth or in a small piece of sponge.

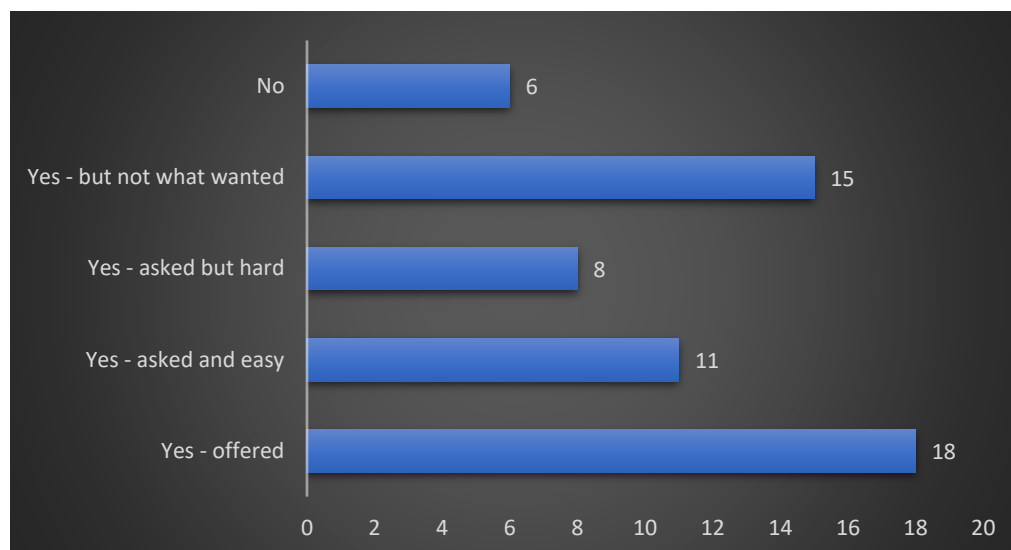
Several focus group participants admitted that once they were on a stable dose of OST they would sometimes divert a day’s medication and sell it in return for food, tobacco, cannabis or hooch.

Continuity of care

Respondents were then asked whether, if they received medication in prison, they were offered a continuing prescription on release. Eighty six survey respondents answered this question and 56 of them wanted medication on release. They were offered the same five answers which reflected ease of access as before. Figure 7 shows that just over half (29/56

= 52%) were either offered medication on release or asked for it and secured it easily. However, almost two fifths (21/56 = 38%) either received no medication or did not get the type or as much as they wanted.

Figure 7 If you wanted a continuing prescription on release, did you get it? (n = 56)



Several individuals who did receive a continuing prescription commented that they received sufficient substitute medication to last between one and three days before seeing their drug worker in the community. Four respondents reported difficulties in getting seen promptly by their community agency and running out of substitute medication.

Four focus group participants also shared difficulties in accessing a continuing prescription on release. One individual was made a follow-up appointment with a drug agency in the wrong town (the city in which the prison was located, as opposed to his home town); two others reported difficulties in getting to appointments in time. They stated that although it was relatively easy to re-schedule an early appointment with a drug worker, it could be several weeks before they were able to see the prescribing physician. In these cases, individuals reported that they had resorted to crime to fund the purchase of heroin.

Quality of care

Although the survey focused primarily on the provision of OST in prison, respondents were also asked three general questions about prison drug treatment:

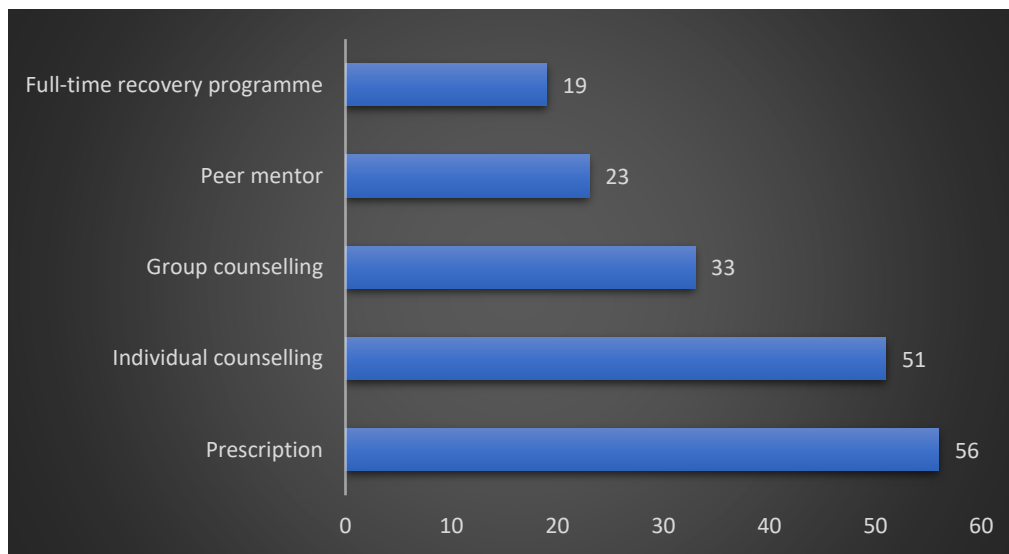
- What help did you get with your heroin/opiate problem inside?
- Please rate your overall satisfaction with the help you were given for your heroin problem in prison?
- Please tell us one thing that would improve help for heroin users in prison?

The responses to these questions are set out below.

Type of help

Over half (51/98 = 52%) of the survey respondents received individual counselling or support; over one third (33/98 = 34%) received group counselling and nearly one quarter (23/98 = 23%) support from a peer mentor; full details are provided in Figure 8.

Figure 8 Categories of help (n = 98)



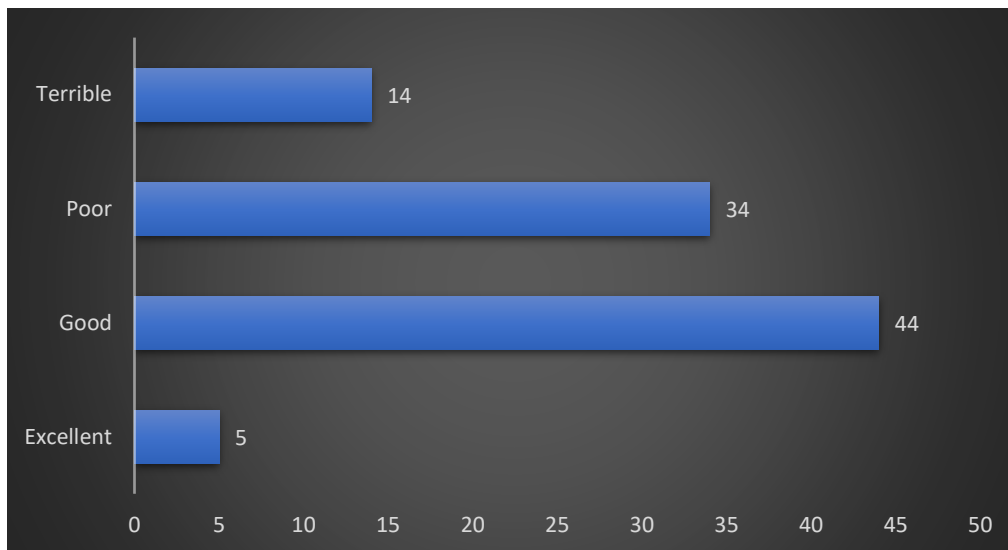
Treatment ratings

Respondents were also asked to rate their overall satisfaction with the help they were given for their opiate problem on a four point scale:

1. Excellent, I really got the help I needed
2. Good, not perfect, but overall I got a lot of help
3. Poor, there were some key things I needed which I just didn't get
4. Terrible - I didn't get any help at all

Opinions were almost equally split with just over half (49/97 = 51%) rating help as good as excellent and 49% rating it as poor or terrible; full details in figure 9:

Figure 9 Treatment ratings (n = 99)



Suggestions for improvements

Almost all (98/102) respondents answered the final question asking for the “one thing which would most improve help for heroin users in prison”. The responses were categorised into the ten main themes listed below in order of popularity:

1. More support available (17 respondents)
2. Improved staff skills and attitudes (10)
3. Listening to prisoners/better communication (9)
4. Reduced availability of drugs, particularly New Psychoactive Substances (7)
5. Recovery wings/prisons (6)
6. Treatment passports – documents recording existing medications to accompany individuals between prison and community (5)
7. Consistent approach between prisons/minimum standards (5)
8. More peer mentors (4)
9. Better continuity between prison and community (3)
10. Narcotics Anonymous meetings (3)

Focus group participants were also asked to nominate the key issues they would like to see improved in prison drug treatment and highlighted four concerns:

1. Access to support for people serving short sentences (no fewer than six individuals reported being offered access to a peer mentor or drug treatment programme in the week prior to release).
2. Reliable access to a proper withdrawal programme (participants were prepared to “trade” a rapid withdrawal for an assurance that they would receive some support).

3. A medical passport system where people could receive the same prescription that they were getting in the community – at least initially.
4. Help with support on release, particularly with accommodation without which they felt it was impossible to even attempt to reduce or control their drug use.

Conclusion

This short study consulted with a substantial cohort of individuals with recent experience of seeking access to OST in prison.

The main findings are:

- The quality of OST varies considerably between establishments.
- There was little consistency of approach with different prisons adopting different prescribing preferences; some favouring methadone, others buprenorphine.
- BAME individuals found it harder to get their prescribing needs met.
- The diversion of prescribed medications is a major concern for many prisons and appears to have substantial impact on prescribing regimes.
- Support for short term opiate using prisoners is lacking even though a large proportion of drug dependent offenders are typically repeatedly sentenced to short prison terms owing to their high volume but low seriousness offending.
- Despite many criticisms, there was an acknowledgement of considerable improvement in prison OST over the last 10-15 years with service users equally split between those who rated their prison drug treatment experience as excellent and good and those who rated it poor or terrible.