# Blocking tactics

A study has found prisoners with class A addictions are more likely to avoid returning to drugs if they are given opioid blocker Naltrexone on release. **Suzanne Midgley** recounts the development of a ground-breaking project in Bristol

BEFORE 2000, the inclusion of Naltrexone prescribing in care plans in Bristol was largely confined to people who had completed inpatient detoxification outside the prison system. The challenge for Bristol Specialist Drug Service (BSDS), a community-based drug treatment service, was to provide effective treatment for service users who had been physically detoxed while in custody. According to our own research, half of them had no previous contact with community drug services nor had the opportunity to learn the necessary skills to manage the psychological aspects of their dependencies.

We began by working to strengthen the links with local and regional prison health care teams to provide Naltrexone induction prior to release. BSDS, which is funded by the Bristol Drug Strategy Team and the South Gloucestershire DAT, was to provide continuation and addiction prescribing to people on DTTOs, those on licence or on bail assessment for suitability for DTTOs or Drug Rehabilitation Requirements (DRRs) and prolific offenders.

Treatment was delivered in Bristol's Inner City Clinic (near the local male prison), the probation area office and the day care centre. The local service users group's opinion was sought, as there is an established open poly-drug market within walking distance of the clinic. Despite this, service users approved the Inner City Clinic as a venue, reasoning that they were likely to live most of their adult lives in areas where Class A drugs were available so temptation to buy drugs was a problem that had to be overcome anyway.

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Mark Harvey at
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## OBJECTIVES

The main aim of the Naltrexone programme was to assist people to achieve abstinence from illicit drugs and criminal involvement through a structured programme of substitute prescribing of naltrexone, beginning prior to release from custody. It was also our ambition to develop people's independence and responsibility (while maintaining family and social networks), to manage the various aspects of recovery and rehabilitation (including drug use, physical and psychological health and social functioning) and to enable service users to comply with court orders. As a result we intended to reduce the rates of relapse into illegal drug use post-sentence, recidivism and incidents of drug-related overdose post prison release.

Finance was raised for an evidence-based study into the Naltrexone experiment, *Crack and opiate users: Naltrexone treatment in BSDS*, was undertaken by the Mental Health and Research Unit at Bath and published last year. The study involved staff from the criminal justice integration team, CARATs, prison health care, probation, prolific offenders team and the drug management team.

Initially, most service users identified themselves as dependent on heroin, but the majority were multiple-drug users: the most commonly-used drug alongside heroin was crack cocaine. Initially, service users told us they were confident they did not have a problem with stimulants. But many were surprised by the extent of their cravings for crack when they started taking Naltrexone and stopped using opiates.

However, staff were surprised when people began to achieve higher-than-anticipated reductions or even cessation of crack use. We had predicted an increase in the use of benzodiazepines, alcohol or cannabis to self-medicate the effects of cocaine, whereas service users reported that using those drugs was ineffective. A third of service users completed clinical questionnaires about their use of crack and other drugs. Nearly nine in ten thought heroin was the most useful drug to ameliorate the crack comedown. Half indicated that if heroin was not available they would not use crack.

## PROGRAMME

Within the criminal justice team we developed a basic treatment programme to meet the needs of this group who were newly abstinent and wanted to maintain abstinence. Its key elements were:

### Urine testing

All participants were expected to be tested for heroin and cocaine twice weekly as part of their court order. Service users could request extra tests if they considered it was a useful external 'reinforcer', particularly when managing a lapse into cocaine or heroin use. To increase self-efficiency and widened choice we also began to teach service users how to use the testing cassettes

at home to self-test and, if they had ceased Naltrexone prior to lapse, refer themselves for a re-induction within 24 hours of testing negative.

### Significant others

At first or second sessions service users would be asked if they could identify anyone who knew about their drug use to be able to recognise signs that a lapse could be imminent and who may want to be involved in supporting their recovery. The three-way meeting would be arranged to discuss possible scenarios, expectations, confidentiality wavers and management of negative events. The inclusive approach proved popular with service users and carers.

### Constant contact

Service users were given my work mobile number with clear boundaries set about appropriate and inappropriate use. They were aware that I would leave every morning from 9am to 10.30am clear of appointments to allow for crisis intervention with anyone who requested the slot and they were able to text me at any time to book themselves in. To date, not one service user has abused this service.

### Contingency management and relapse prevention

Service users were urine tested prior to the counselling session. Provision of a supervised urine sample negative for heroin or cocaine resulted in the service user setting the agenda for the counselling session. Provision of a sample that was positive resulted in the session focusing on relapse prevention. This was not negotiable. Certificates, which proved popular, were given on completion of induction. The probation team was able to offer further re-enforcement for desired behaviour, for example abstinence from class A drugs would be rewarded with bus passes or cinema tickets.

### NEGATIVES

Service users and staff in all settings expressed two main negative perceptions of the scheme: the side-effects and the risk of overdose. A third of service users experienced minor side-effects such as feeling ill, headaches, abdominal pain and, most commonly, muscle stretching. But of these, many said they were "a small price to pay to be clean and to be safe".

But we discovered that most of the side-effects disappeared when people were reduced to 25mgs rather than 50mgs of Naltrexone. Service users did not immediately identify that Naltrexone was helpful for preventing their crack cocaine use although when asked, commented "knowing that I am not going to use heroin takes away the craving for crack cocaine"; "if I don't have heroin, I wouldn't take crack" and "if I can stay away from heroin, I can stay away from crack".

Interviews with prison staff indicated that there were problems with conflicting agendas such as "making sure people are released" as opposed to "making sure people have incentives to get into treatment". Pressures of other healthcare demands resulted in difficulties in attending clinical meetings. The process was also perceived as lengthy, with service users saying they can be asked the same assessment questions on three occasions.

> **"Half indicated that if heroin was not available they would not use crack**

Service users also expressed feelings of anxiety, uncertainty and fear about stopping Naltrexone. To manage this understandable anxiety at this stage, they were offered the opportunity of taking Naltrexone on alternative days or reducing the dose. On ceasing Naltrexone, service users had a reduced tolerance for opiates, so education and training in this area was vital. It is becoming increasingly clear that clinicians duty of care may extend beyond cessation of dosing and cessation of drug-free residential supervision. None of the service users accessing Naltrexone in this study overdosed.

### SAFETY NET

Despite the negatives, the study concluded that most service users interviewed reported favourably about Naltrexone, describing it as "good for staying clean", "a blocker", "a tool to stay stopped", "security and protection" and a "safety net".

Amongst other recommendations, the report concludes that there is evidence that Naltrexone is useful for those who use both heroin and crack cocaine and that induction while in custody is significant – as 90 per cent went on to continue treatment.

A 2003 Home Office report recommended that consideration should be given to developing pilot programmes for the use of Naltrexone and I would welcome contact from any other practitioners involved in such work.

With the new developments in Prison Integrated Drug Treatment Programmes it seems appropriate that, in addition to substitute prescribing, further consideration is given to the availability of treatment with antagonists such as Naltrexone for prisoners prior to release, with local services providing continuation prescribing and counselling. ●

*Suzanne Midgley is a drugs worker at BSDS*

## THE OPIOID BLOCKER

Naltrexone is a narcotic antagonist. It works by blocking the opioid receptors in the brain and therefore blocking the effects of heroin and other opioids. It has also been shown to reduce craving and consumption for some patients who are alcohol dependent. Those who take it know that they cannot achieve a 'high' from using heroin and that any money therefore spent on heroin will be wasted. It does not directly stop a person wanting to use heroin, although it may reduce or prevent cravings in some people.