Staying power

Is methadone maintenance the answer to reducing the prison population? Is it just an expensive alternative to cold turkey? **Mike Ashton** looks at the evidence

As English prison policy finally embraces methadone maintenance (practice has still to catch up), evidence for its effectiveness took a major leap forward with the first randomised trials to show that the benefits outlast the offender's sentence.

At the end of last year the Department of Health's new prison health policy called for pre-custody maintenance to be continued in prison and for all short-term and remand opiate-dependent prisoners to be offered the same treatment regardless of pre-prison treatment. Prison doctors were also advised to consider initiating maintenance before release to protect these prisoners from overdose.

Earlier trials and experience in at least five EU member states showed that maintenance in prison was feasible and caused few operational problems, that the patients reduced their opiate use, injecting, and sharing of injecting equipment, that the overdose rate fell, and that prison discipline and climate improved.

But all the studies lacked a crucial ingredient – a randomly selected comparison group of prisoners the same in every way as the methadone patients except for the fact they took no methadone. Without this it is impossible to be sure that the apparent benefits were due to the methadone treatment and not to some quirk of the prisoners who opted for it or the prisons that implemented it.

That gap was filled by an Australian study initiated in the late '90s which produced its first report in 2003. 382 male prisoners on a waiting list for methadone maintenance were randomly allocated to immediate treatment or to a four-month wait. The wait was shorter than normal, defusing potential resentment. Interviews of the prisoners were confirmed by hair samples.

Over 80 per cent had used heroin in the month before the study started. Among those offered methadone, this fell to 32 per cent by two months and a quarter by four months. Meantime, two thirds on the waiting list were still using. Reduced heroin use was the main reason for substantial cuts in the proportions injecting (from 64 per cent to 34 per cent) or sharing syringes (from 53 per cent to one fifth), risk behaviours which became slightly more common among the waiting list prisoners.

It was a convincing demonstration that while still in prison, patients benefited from methadone maintenance and that it cut illegal drug use to a degree which attempts to intercept drugs had been unable to achieve. Perhaps importantly, the programme's dosing appears to have been flexible and reasonably generous (averaging 61mg).

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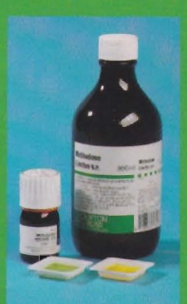

Four years later the researchers re-contacted all the prisoners they could – two-thirds of the 365 were still alive (17 had died – all while out of methadone treatment). Published in Addiction in 2005, the report showed how important it was to continue treatment on release. Nearly all the prisoners had been released from their initial sentence. Most had later been re-imprisoned, but this was far less likely if they had received sustained methadone treatment, and the longer someone had stayed on methadone, the less likely they were to have become infected with hepatitis C.

In the very different environment of the USA, a second randomised trial tested whether starting methadone in prison would encourage its continuation on release. In Baltimore researchers recruited prisoners already in prison for at least a year. Within three months of their release date they were randomly allocated to normal procedures or to begin maintenance on LAAM, a long-acting derivative of methadone taken three times a week. Continued treatment from the same provider was available on release.

Among those who could be re-interviewed nine months after release, 20 out of 33 offered LAAM in prison had entered treatment after release and half had remained in treatment for at least six months. In contrast, just three of 31 prisoners not offered LAAM had entered treatment. Crime and drug use indicators in the nine months after release consistently favoured offenders who had started treatment in prison. Since they were as criminally active as the remainder before prison, the implication is that offenders whose offending is driven by opiate dependence will accept, continue and benefit from substitution treatment started in prison, and that this will cut crime – so long as arrangements are made for their seamless transfer to a similar programme when they leave.

Methadone in prison is no panacea. Even if prison authorities are prepared to make it available, many prisoners will reject the offer because they see prison as an opportunity to become drug-free. The tragedy is that very many of these will lose their resolve on release, and many of these will die due to resumption of opiate use having lost their tolerance to the drugs. ●

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