THE DRUG DETOX UNIT AT MOUNTJOY PRISON – A REVIEW

By Dr. Des Crowley, General Practitioner

INTRODUCTION

The Drug Detox Unit was opened in July 1996 at Mountjoy Prison in response to the escalating drug problem in the prison. It was designed as a seven week programme which included an initial ten day methadone detox and a six week intensive rehabilitation module. Entry to the programme is by interview. Prisoners are assessed in terms of their drug history, criminal history and motivation to change. The Department of Justice have the final veto on entry onto the programme.

The medical elements of the programme are provided by a part-time doctor (G.P. with specialised interest in drug addiction), and a complement of six nurses who provide 24 hour cover to the unit. The methadone detox usually lasts between 8 and 14 days and prisoners tolerate the detox very well; 50-60% of prisoners entering the programme have required either a Methadone or Benzodiazepines Detox. Detoxing prisoners in a unit like ours is much easier than community detox because most of the prisoners having spent some time in prison have a greatly decreased drug tolerance. While we hear a lot about drug use and availability of drugs within the prison system, a point which is rarely made is that prisoners use far less drugs in prison than in the community. This is due to reduced availability. Unfortunately because of the inconsistency in the Heroin supply prisoners tend to use sporadically and tend to use unsafely. In designing drug treatment services within the prison system one needs to be aware of this point.

Up to February 1999 187 prisoners had entered the programme. Of these, 173 completed and 14 failed to complete the detox. This is a 93% success rate for people being drug free at the end of the detox programme.

Successfully Completed	173
Unsuccessfully Completed	14
Total	187

While a 93% success rate seems very high the important figures for determining the success of this intervention are 6 and 12 month relapse figures. These will be discussed later.

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1. PRISONER PROFILE

The following statistics are compiled from our addiction assessment form which is completed on every patient prior to commencing the programme. While some of the information is of an indisputable factual nature, some is self reported and consequently has limitations.

Sex Profile:..... 100% Male
Age Profile:..... Average Age 26.3 years
Range: 18-42

The average age of the patient on the detox programme is 26.3years. I feel that this is too high. The best time to intervene with drug users if one hopes to get them drug free is in the pre-addicted phase of their drug taking. However, it is very difficult to target or engage this group of people since generally they themselves do not identify that they have a problem and also they tend not to have spent time in prison. If one cannot identify pre addicted users then the best outcomes are in those with the earliest intervention after they have become addicted. Most of this group of drug users are regularly using drugs in their mid to late teens.

We need to constructively look at providing structured detox facilities in Detention Centres and in St. Patricks youth Institution. The key to early intervention is early detection and since many of our prisoners come in contact with the criminal justice system early in their teenage years, we have a great opportunity to pick up these young users and offer them appropriate treatment.

SOCIAL PROFILE

Live with Family	66%
Live with Partner	28%
Live Alone	6%
Partners have history of Drug Use	40%
Partners no history of Drug Use	60%

Have Children 65%
Have No Children 35%
Average Number of Children.....2.5
Range 1-5
Average age of Child ..... 4.8 years

EMPLOYMENT

Unemployed on entry to Prison..... 78%
Previous work or training..... 50%
No history of Work 50%

As expected a large proportion of our group were unemployed before starting their present prison sentence. A figure of 50% for no history of work is disturbing.

It reflects the amount of resources that are required to tackle one of the underlying root causes of addiction, that is long term unemployment. A large amount of money is required to put in place suitable training and rehabilitation courses both in the prison and the community. These rehabilitation courses need to reflect the needs of this population group and need to focus on literacy, addiction and self esteem. Most of the present Community Employment and Fas Schemes do not fulfil these criteria.

FORENSIC HISTORY

Average number of previous convictions 16.2

Average sentence length ..... 3.8 years

Average age of first contact with criminal justice system 13.8

It is worth noting that the average number of previous convictions for this group of prisoners was 16.2. Since most of these convictions are for drug related crimes it is quite astonishing that it is only on their present conviction that these group of prisoners have been offered a significant chance at rehabilitation concerning their opiate addiction. All prison sentences should have a significant rehabilitative component. Another point worth noting is that the age of first contact with the criminal justice system was 13.8 years. Since he average age of prisoners entering our programme is 26.3 years most of our group have had over 13 years history of criminal activity before being offered drug treatment and rehabilitation in our criminal justice system. This is a terrible indictment of our policy makers. The average age of first contact with criminal justice and first use of illicit substance is the same. It would indicate that if we could target early offenders with drug treatment we may stop this revolving door cycle. To pick up this group, young offenders should all have full drug assessments and urinalysis done when they come in contact with the criminal justice system.

DRUG TAKING PROFILE

Average Age of first use of illicit substances other than alcohol: ..... 14.2 years

SUBSTANCES FIRST ABUSED:

Cannabis 80%

Benzodiazepines 15%

Methadone 3%
Ecstasy 2%

The gateway drugs for this group of people are as expected, with Cannabis, Benzodiazepines figuring highest. Many of the prisoners give histories of having stolen their mothers Benzodiazepines and for many this was their first experience with mood altering drugs. Also an interesting point from these statistics is the appearance of Methadone as a gateway drug and as a drug of primary abuse. While the figures remain low we need to be vigilant in limiting street leakage and of making young people aware of the dangers of Methadone use particularly when used in a poly drug scenario. Many prisoners would initially have used Methadone to potentiate the effects of alcohol.

METHOD OF USE

Injectors 92%
Smokers Only 8%
Age of first Heroin use ..... 15.2 years (Av)
Age of first Needle Use ..... 16.5 years (Av)
Self reported needle sharing pre Prison 60%
Self reported needle sharing in Prison 98%

The low percentage of smokers would reflect the age group in this cohort. The vast majority of our group injected in the prison and many who had reported use of needle exchange and clean needles on the outside were forced within a prison setting (with low availability of needles and heroin), to resort to sharing needles. While most prisoners said they clean their works with bleach which was available in a non structured fashion, it is still highly unsatisfactory in terms of harm reduction and viral spread control. Cleaning works with bleach is sufficient to limit HIV spread but is unsatisfactory in limiting Hepatitis C spread.

In recent years our harm reduction measures in the community and with wider availability o0f methadone maintenance, have meant a huge reduction in HIV spread among injecting drug users. While it is important not to become complacent about the spread of HIV we need to focus and channel our resources to combat the alarming Hepatitis C epidemic which is engulfing our drug taking community; 80-90% of IV drug users are Hepatitis C positive. What is more alarming is that most of these have acquired the Hepatitis C virus very early in their drug taking history and most are Hepatitis C positive before engaging with drug treatment services in the community. I feel our criminal justice system is negligent in not providing safe needles, bleaching tablets, and, above all, intensive education around viral spread prevention within prisons.

DRUGS USED

Tobacco..... 99%
Cannabis..... 98%
Benzodiazepines..... 90%
Alcohol..... 90%
Cocaine 85%
Ecstasy 60%

From these figures it is clear that most drug takers in our prison system are poly drug users. And while tackling their opiate addiction we also need to channel resources into the abuse of other substances particularly the socially acceptable abuse of alcohol. Many drug users will transfer their abuse between substances.

OUTCOMES

Of the 173 successful prisoners at the time of the preparation of this report we were unable to follow-up 20 prisoners. Of the ones followed-up, 4 had died, 67 were drug free in the training unit, 13 were in the main prison, 13 were in other institutions and 56 were either in Coolmine or the community. It is difficult to estimate accurately the number who remained drug free after completion, as many of the prisoners do not have regular urinalysis done. It is reasonable to assume that the 67 prisoners in the training unit remain drug free. We estimate that a further 35 prisoners remain drug free either in the community or Coolmine.

In our first 12 months review we followed up 86 prisoners who had completed the programme. At the time of preparing the report 36 had returned to drug use. We were unable when compiling this report to follow up all 86 prisoners. We however managed to locate 70 of the original 86 and again found from self reporting and staff follow up that a further 15 patients had relapsed thus giving a total number of 51 prisoners out of 86 who had relapsed. If we assume that the 16 patients we were unable to follow up had also relapsed this would give us a 12 monthly relapse rate of 78%. This figure may appear high but is favourable when reviewed in comparison to inpatient detox programmes internationally which have on average a 90% relapse rate.

While an intensive rehabilitation programme could be attached to our present detox programme when patients are transferred to the training unit, it is unlikely that we would significantly improve our figures. The benefit would be that people who stay drug free would do better and would probably end up fully integrated back into community life. The figures for detox relapse have always been incredibly high and still many people cannot accept substitution

treatment as being a valid intervention. A total drug free existence should be our aspiration for all patients but the reality is that only a small percentage will ever retain a drug free life once they have become opiate addicted. Consequently people should not have to choose detox or no treatment. Many of the people on our detox programme would probably have done better and would have been suitable for methadone maintenance. The detox programme should however be maintained and expanded to offer this facility to the highly motivated group of people who are aspiring to a drug free lifestyle.

A point worth noting is the high numbers of deaths in our drug free cohort. Three of the four deaths were drug related and all four deaths occurred shortly after the prisoner leaving prison. After detox a patient's tolerance for drugs is drastically decreased and patients leaving a detox programme are at a much higher risk of overdosing if they restart opiate use. All prisoners leaving detox programmes should be warned of the potential for overdose if they relapse. Given the relapse figures this is a high probability. Even prisoners who have not become totally drug free in prison have a much lower tolerance for opiates because of the decreased availability in the prison setting. They too are at serious risk of overdosing in the immediate period following discharge from the prison.

METHADONE MAINTENANCE

The debate around methadone maintenance has clearly come down on the side of accepting that it is the single most effective intervention in opiate drug treatment. The provision of methadone maintenance is endorsed by the Department of Health and the Eastern Health Board and huge amount of resources are dedicated each year to the provision of these services in the community. People maintained on Methadone in the community do not continue on this treatment when they enter the prison system.

A survey done in March 1998 on new committals entering Mountjoy showed that out of a total of 479 committals, 87 prisoners were receiving methadone maintenance in the community. Of these, 51 were receiving Methadone maintenance in Eastern Health Board run Treatment Centres and Satellite Clinics, while 36 were receiving Methadone from private G.P.s. With the introduction of the new Methadone Protocol in October 1998, all methadone provision is monitored by the Eastern Health Board, including those receiving methadone treatment from G.P. s. The new system is very structured and allows for very little abuse of the system. Most people on methadone maintenance have been placed on this treatment after multiple assessments by experienced doctors in substance abuse. These include Consultant Psychiatrists and Specialised General Practitioners. The treatment of opiate addiction by methadone maintenance is recognised internationally as the treatment of choice for the majority of opiate dependant IV drug users. Yet this treatment is discontinued when a patient enters prison.

A safe environment, where people can be sure to be in as near as possible a drug free space and where urinalysis can be undertaken on a bi-weekly basis, is required. Also the provision of addiction counselling services and proper nursing care needs to be initiated.

The provision of suitable space requires internal reworking and organisation of present prisoners which could be achieved if there was sufficient will in prioritisation of drug treatment services within the prison system. I feel that the provision of methadone maintenance within the prison system could be the most significant intervention in the reduction of criminal activity stays in prison, and viral spread, and is a reasonable aspiration as we approach the millennium.