

**The Role of Methadone Maintenance in Scottish Prisons:
Prisoners' Perspectives**

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CHAPTER 1. INTRODUCTION

Background

Drug use in prisons

The UK has one of the highest rates of problem opiate use in Europe with a prevalence of 6 cases per 1000 population (Kraus et al, 2003). After an injecting career of four years, 74% of injecting drug users (IDUs) will have been imprisoned at some time and IDUs not in some form of drug treatment are even more likely to be incarcerated than those who are in treatment (Farrell et al, 1994).

In Scotland, 25% of prisoners test positive for drug misuse on arrival in custody and a recent study in HMP Shotts (Champion et al, 2004) reported that 15% of inmates injected drugs whilst incarcerated. In other Scottish prisons, between 27 and 35% of prisoners are IDUs and, of these, 28-67% inject in prison (Gore et al, 1999) Virtually all injecting in prison occurs with used injecting equipment shared among numerous partners (Taylor et al, 1995).

Substitution treatment: Methadone

Methadone reduces heroin withdrawal symptoms and craving and in higher dosages blocks the euphoric effects of heroin. It was first proposed as a treatment for heroin addiction by Dole and Nyswander in 1965 (Dole and Nyswander, 1965). The half-life of methadone is approximately 24 hours, which enables once daily dosing. Steady and adequate dosages of methadone have been considered vital for the success of methadone maintenance programmes. To prevent withdrawal symptoms a dosage of 20-40mg per day is adequate but to reduce or eliminate craving and to block the euphoric effects of illicitly self-administered opiates a daily maintenance dosage of 60-100mg has been advised (Langendam et al, 1999). Steadily increasing the methadone dosage in a harm reduction setting may be useful in supporting IDUs in the process of cessation of injecting, for periods of greater than one year, and reducing the spread of blood borne viruses (BBVs) (Langendam et al, 1999).

Alternative therapies to methadone are buprenorphine and naltrexone. Buprenorphine is an opioid with agonist and antagonist properties, that is, it both produces and blocks the effects of heroin. It can therefore be used as a substitution therapy for prisoners with moderate opioid dependence. In patients on high doses of heroin it may however

precipitate withdrawal due to its partial agonist properties. Naltrexone is an opioid antagonist, thus it blocks the action of heroin and precipitates withdrawal in heroin addicts. Since the euphoric action of heroin is blocked by naltrexone, it is given to former addicts to aid relapse prevention. Unfortunately, many experience side effects whilst on it.

Evidence of Effectiveness: community

In the community there is abundant evidence that methadone maintenance treatment (MMT) reduces injecting, reduces the illegal use of opiates, reduces spread of infection, improves employment levels, and reduces crime and subsequent incarceration among heroin-dependent patients (Ward et al, 1998; Abdul-Quader et al, 1987; Schoenbaum et al, 1989; Farrell et al, 1994; Hutchinson et al, 2000). In Scotland, an association was found between methadone maintenance therapy in a clinic setting and a reduction in criminality amongst males (Bates and Pemberton, 2001). Patients retained on methadone programmes in the general practices in England also had significantly fewer convictions and cautions, and spent significantly less time in prison than they had before the start of treatment (Keen et al, 2000). Similar findings have been found internationally (Anglin et al, 1981; Stenbacka et al, 2003).

Other studies have focussed on the effect on illicit drug use. In Scotland, treatment of opiate-dependent drug injectors with methadone in a community-wide general practitioner-centre scheme was associated with major beneficial change for a substantial proportion of patients in terms of illicit drug use (Hutchinson et al, 2000). Up to 2 years in-treatment follow-up of clients in a Lothian Community Drug Problem Service also revealed significant improvement in injecting and criminal behaviour (Peters and Reid, 1998). This has also been reported elsewhere (Graham-Bafus et al, 1984; Gossop et al, 2000). Risk-taking behaviour has also been shown to decrease (Stark et al, 1996). In Australia, The National Treatment Outcome Research Study (NTORS) was one of several studies that found significant reductions in the use of all illicit drugs at follow-up for patients recruited to methadone maintenance and methadone reduction treatment programs and concluded that these changes represented important clinical benefits to the individual clients, to their families, and to society (Marsch, 1998; Gossop et al, 2000; Merrill et al, 2005). Similar wide reaching positive outcomes were reported by Keen et al in a study in the UK which

looked at current drug use, HIV risk-taking behaviour, social functioning, criminal activity, and mental and physical health (Keen et al, 2003).

Importantly, numerous studies have shown MMT to be cost-effective across a variety of outcome measures. (Sidwell et al, 1999; Barnett, 1999). An article in the Canadian HIV/AIDS Policy & Law Review stated that “the cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT.” (Anonymous, 2002).

The general health of heroin users entering methadone maintenance is very poor in relation to population norms. Improvement in health related quality of life is also reported after receiving MMT. MMT is also cost-effective with respect to life-years gained (Barnett, 1999). Also, for every pound spent on treatment, it has been estimated that £3.00 is saved in crime associated costs. Further research is required to produce information on the impact of methadone treatment on the cost of healthcare and the indirect costs incurred by patients and adjustments to reflect quality of life.

Wide reaching outcomes are favoured by the National Alliance of Methadone Advocates (NAMA), which resists the tendency for evaluators to focus on illicit drug use. As the premier methadone advocacy organization and the voice for methadone patients, NAMA promotes the view that methadone patients are to be judged by the contributions they make to their families and communities not by whether they sometimes use other illicit substances (Woods J.)

Thus, research evidence supports the argument that community MMT programmes can produce favourable outcomes to the individual receiving treatment and the wider community. For the individual, receiving treatment in the community, MMT can bring rapid benefits that include: relief from the distress of withdrawal, reductions in drug use, cravings for opiates, risk of overdose and the need to deliver drugs by injecting them. In the longer term, MMT can help to improve the health of the individual recipient and provide the basis from which to lead a more stable life. These benefits can in turn lead to positive consequences for society at large.

There are, however, problems associated with MMT in the community. There is concern that MMT is becoming an “end state” in itself for individuals receiving it. It could be seen to be a barrier to real change, almost putting an obstacle in the way of the aim for abstinence and a life free from drugs (Dolan et al 2005, 1998; Stoever, 2002; Neale and Saville, 2004).

It is recognised that despite substantial benefit for the majority, there is a subgroup of individuals for whom long-term methadone treatment, even on high doses, has no beneficial effect on criminal activity or drug use. Further research is required to establish the dynamics of this indirect treatment-benefit, and to explore the apparent resistance to treatment of the criminal behaviour of a small sub-group (Sidwell et al, 1999). It is also suggested that there is no good scientific evidence that dispensing methadone to non-compliant patients is an effective intervention. This is supported by studies at the Royal Newcastle Hospital which show that the longer the non-compliance the greater the failure rate. The dangers of continuing to prescribe methadone to patients using other illegally obtained drugs is emphasised and alternatives to methadone maintenance (including therapeutic communities, narcotic antagonists, drug-free counselling, needle exchange programmes and benign neglect) are encouraged in this subpopulation (White, 1994).

Although there is a body of evidence that suggests that community MMT is beneficial, there are, however, no specific models of community practice that are considered the gold standard approach. The provision of methadone in the community in Scotland and the UK, for example, has never been characterised by a centrally co-ordinated policy and this has meant that there exists great diversity in MMT provision. Thus, all medical practitioners have the authority to prescribe methadone (in oral or injectable forms) as they individually consider best.

Despite these problems, nearly 30 years after Dole and Nyswander introduced methadone maintenance treatment in the community in 1965 about a quarter of a million drug users received methadone maintenance treatment globally in the community (Farrell et al, 1994). However there was not a similar situation in prisons and, in 1993, in response to growing international concern about the gap growing between drug treatment provision in the community and in prisons, the World Health Organisation (WHO), published ‘Guidelines on HIV and AIDS in prisons’. One of

the central conclusions of this work was that healthcare in prisons should as far as possible match that available in the community. After much discussion internationally about the provision of MMT in prisons, several different countries are now following the community lead and allowing MMT programmes in prisons (EMCCDA2002). Scotland is one of these countries.

Evolution of the SPS policy on methadone

Between April and June 1993, 8 cases of acute clinical hepatitis B infection and 2 seroconversions to HIV infection were detected among drug injecting inmates of HM Prison Glenochil in Scotland. To prevent the further spread of infection, an initiative which involved counselling and voluntary attributable HIV testing was conducted over a 10-day period commencing at the end of June. A team of 18 counsellors and phlebotomists was brought together rapidly as part of a unique organizational exercise in the field of public health. Fourteen cases of HIV infection were identified of which 13 were almost certainly infected in HMP Glenochil (Taylor et al, 1995). Following the exercise, a range of harm reduction measures for injecting prisoners was introduced; these included the availability of hepatitis B vaccine, provision of bleach tablets which could be used to clean injecting equipment, a methadone detoxification programme, increased training for prison officers and improved access to drug and harm minimization counselling for inmates. By mid-1996 all these measures had been sustained and several could be found in many other prisons throughout Scotland. The Scottish Prison Service (SPS) responded to the problem of drug misuse with the strategy set out in '*Guidance for the Management of Prisoners who misuse Drugs*' in 1994. This described that methadone was available in prison as part of a short-term detoxification protocol only. However, in 1999, the Scottish Prison Service reviewed its existing policy on drug misuse in prisons and a new healthcare standard, 'standard 10' was introduced. Healthcare standard 10.1,1 states 'If a prisoner has been on a treatment programme in the community, then they should be offered the opportunity of continuing this in prison.' Healthcare standard 10.1,5 states 'Initiation of a Methadone script should only occur when a full and comprehensive assessment identifies clear risk factors appropriate to the initiation of a Methadone script, where Methadone prescribing is part of a full and comprehensive treatment programme involving support and counselling'. Thus, Health Care Standard 10 states that methadone maintenance substitution treatment could now be continued or initiated in

prison where previously methadone was only used as part of a rapid 5 day detoxification programme.

Resources followed this development in policy such that by 2003 all SPS establishments could prescribe methadone maintenance treatments.

A new strategy was produced in 2000: *Partnership and Co-ordination: SPS Action on Drugs*. This strategy sets out 4 objectives:

1. To reduce the amount of drugs of misuse of all types entering and trafficked within prison establishments
2. To encourage drug misusing prisoners to present for treatment whilst in custody
3. To increase the proportion of identified drug misusers entering prison based drugs interventions
4. To increase the proportion of identified drug misusers taking part in successful through care arrangements.

In July 2003, 587 prisoners were in receipt of a substitute prescribing regime, by June 2005 this figure had increased to 886 prisoners (personal communication (2)).

To evaluate its policy on methadone maintenance the SPS commissioned research to research the effectiveness of the change in MMT policy in achieving the drug strategy objectives (MMT has the potential to effect objectives 1, 2 and 4) and also its broad role in how it affects prison life, for the individual receiving it and collectively.

Aim

The principal aim of the study was to examine the role and impact of methadone maintenance treatment among different prisoner sub-populations.

Objectives:

1. To provide an overview of policy and practice on methadone maintenance within the SPS and in other settings;
2. To establish why intravenous drug users (IDUs) decide to start MMT in prison;

3. To examine prisoners' perceptions of the process of methadone prescribing in the prison setting;
4. To enquire into what affect MMT has had on their quality of life in prison;
5. To investigate the impact of methadone on behaviour including areas such as risk behaviour avoidance, social interactions, relationships and networks. To consider prisoners' perceptions on whether methadone maintenance alters prison dynamics and decreases levels of violence or intimidation between prisoners;
6. To consider whether methadone replacement motivates drug users to seek help to address social and psychological problems attendant with incarceration;
7. To enquire into why some drug users may choose not to receive methadone.
8. To elicit prison staffs' view of the effect of substitute MMT on prison life

Methodology

When addressing policy issues, there is a need to understand complex behaviours, needs, system and cultures. Although there may be a heritage of policy-makers wanting 'hard facts' that are produced by quantitative research, increasingly it is realized that qualitative research has a key role in providing insights, explanations and theories of social behaviour and can thus aid the formation of policy. Accordingly, for this study, qualitative interviewing was chosen because it can delve deep beneath the surface of superficial responses to obtain meanings that the prisoners and staff assigned to events and to explore the complexities of their attitudes, behaviours and experiences. Interviews allowed individual prisoners and staff to tell their own stories in their own words.

Ethical Aspects

The basic ethical principal governing research is that respondents should not be harmed as a result of participating in the research and they should give their informed consent to participate. In this research 'informed consent' meant that the participant understood the nature and purpose of the study and how it related to them. A consent form (appendix 1), stating the above, was required to be signed. The research protocol was passed by the SPS Research and Access Committee and a properly constituted ethics committee at Lanarkshire Health Board in November 2002. As the study enlarged to involve further prisons, the ethical permission granted by Lanarkshire Health Board was sufficient as judged by COREC.

Prisoners were recruited to the study by a prison official. A study information sheet (appendix 2) was provided and the consent form was signed by the participants before entry into the study. The participants were informed that they were free to withdraw at any time without any adverse consequences.

Data was treated confidentially in accordance with data protection, freedom of information and privacy legislation. Tapes were stored securely and were destroyed at the end of the study.

Sampling Strategy

Sampling strategy has implications for whether and how generalisation is consequently possible. The sample was chosen to give access to data that allowed empirically and theoretically grounded argument about the key issues. Sampling was strategic. The aim was to produce, through sampling, a relevant range of contexts or phenomena, which enabled the development of well founded argument. The sample was designed to encapsulate a relevant range in relation to the wider prison population in Scotland, but not to represent it directly. The data collected from the sample is intended to provide the range of data that would be accessed from the entire prison population were they all to be interviewed.

Theoretical sampling involves the generation of conceptual or theoretical categories during the research process. The sample of prisoners and staff was constructed to have certain characteristics or criteria which helped develop and test theories that emerged during the study.

Prisoner groups

Prisoners were recruited from each of the five prisons. In total 90 interviews were conducted as part of the main study. Different prisoner groups were interviewed. Long-term, short-term and women prisoners. Young offenders (YOs) were notably not included as there were insignificant numbers of YOs on PMMT. (personal communication 1). The numbers of prisoners to be interviewed had to be estimated to provide a practical framework to work to, although it was anticipated that the exact numbers sampled would vary from this for reasons discussed below. The sample was therefore initially stratified into 30 long-term male prisoners, 30 short-term male offenders and 30 female offenders. Each group was divided into two groups of 15

from two different establishments. This was to decrease any bias from prisoners from one establishment only.

Within the three different prisoner groups, sub groups with specific characteristics were sought. The sub groups were chosen to encapsulate a meaningful category of experience with respect to PMMT and the research questions. Thus the study groups were meaningful theoretically and empirically because they built in certain characteristics to help develop and test theories. The sub groups were prisoners:

1. Stable on MMT
2. Waiting/wanting to start MMT
3. Removed from MMT
4. Voluntarily reducing level of methadone on MMT
5. Re-prescribed as part of an individual care plane
6. Drug users not wanting MMT
7. Non drug users
8. Pregnant women

Staff Groups

A total of 17 individual interviews were conducted between March and December 2004. A wide range of staff groups were interviewed: governors, doctors, addiction nurses, mental health nurses, clinical managers, residential prison officers, addiction prison officers, prison officers involved in operations (e.g. escorting prisoners around the prison) and Cranstoun workers (drug workers from a private company with a contract with the SPS) The numbers of staff to be interviewed had to be estimated to provide a practical framework to work to, although it was anticipated that the exact numbers sampled would vary from this. The sample was to be 3 or 4 staff in each establishment

The sub groups were chosen to encapsulate a meaningful category of experience with respect to PMMT and the research question. The study groups were meaningful theoretically and empirically because they built in certain characteristics to help develop and test theories. These sub groups were intended to cover the different contexts that apply to PMMT in the prison setting. Sampling across a range of contexts let us use the detail not only to understand specific contexts of PMMT but

also how PMMT works in differently or similarly in other relevant contexts. From there cross-contextual generalities can be developed which are well founded because they are based on the strategic comparison of specific contexts, whose significance to the wider staff population can be demonstrated.

Decisions about whether the ‘right’ number of participants in each category were included was subject to change as the study developed and decisions about what was needed to be compared and the extent to which the sample already generated enabled us to do that. Ideally, as Bertaux and Bertaux-Wiame (1981) suggest, the sample size would be partially dictated by the social process under scrutiny; sampling should continue until theory saturation point was reached – until the data stopped telling us anything new about aspects of MMT in prison. Thus it would difficult to anticipate exactly in advance when this point would be reached. In purposive sampling, the processes of sampling, data generation, and analysis are viewed dynamically and interactively. However the number of prisoners and staff interviewed was also limited by time and resource constraints. The numbers sampled in each sub-group were also dependent, to an extent, on the availability of prisoners and staff in each of these groups.

Characteristics of Study Location/Recruitment setting

Scottish Prison Service staff were accessed from five SPS establishments. These establishments were chosen as they held different prisoner subgroups (long-term, short-term and female prisoners).

Addiction team group discussions

Prior to commencing interviewing in each establishment, group discussions were held in each establishment. Groups contained a range of occupational representatives. Participants were asked to consider the benefits and problems associated with all aspects of MMT in the prison in which they were employed. These discussions were not recorded, but notes were taken throughout and written up immediately afterwards. Discussions were also held with governors in key establishments. Key issues were noted and informed the basis of the semi-structured questionnaire.

Semi-structured interviews

The interviews were conducted between March 2004 and December 2004. During this period there were no policy changes of note with respect to PMMT. Interviews with prisoners and staff explored the effect they perceived that PMMT had on individuals' lives and on prison life. Their views on PMMT were also sought. Participants were asked to talk about the processes involved in the management of MMT in prison.

The large research questions that the study was designed to explore were subdivided into 'mini-research questions', ideas were developed about how to 'get at' the relevant issues in an interview situation, and thus interview topics were generated. The format of the interviews was intended to be flexible. The interviews were an interactional exchange of dialogue, a "conversation with a purpose," they were thematic with a relatively informal style. Prompts used were 'can you tell me more about...' or 'what happened then' or 'why do you think that? Often there was just agreement between sentences by the use of words such as 'right'. If more depth was required on a certain topic then that could be re-explored later on in the same interview. All interviews were audio-recorded and transcribed verbatim.

Analysis

During the initial process of data collection, there was constant comparison of data from interview to interview. Theory emerged quickly and, at this point and subsequently, data were compared to theory. Thus, the analytical process began during the data collection phase with sequential analysis; tentative conclusions were developed and hypotheses for subsequent interviews formed. Negative or deviant cases were then also being looked for.

The researchers checked all transcripts for consistency and accuracy by reviewing both transcripts and recordings. Atlas Ti and Nudist software was used for analysis of transcribed interview data.

Data were preserved in textual form and indexed to generate and/or develop analytical categories and theoretical explanations. The categories were derived inductively, that is obtained gradually from the data. Thus themes (codes) were identified and were then verified, confirmed and qualified by searching through the data. Further themes (codes) would then be examined in a similar way.

Multiple coding involves the cross-checking of coding strategies and interpretation of data by independent researchers. Codes agreed by the two researchers formed the basis of a coding structure developed from the data, using these inductive techniques. The researchers ensured clarity about what each code represented, thus they could be used consistently, appropriately and strategically.

Reading the data

The data were read literally (the words and language used, the sequence of interaction, the form and structure of the dialogue and the literal content were examined) and interpretively (the construction of a version of what the researcher thought data meant or represented or what can be inferred from it).

Reflexive readings locate the researcher as part of the data. It is acknowledged that this would have occurred, and this is examined under the discussion section.

Confidentiality and anonymity

Prisoners and staff were assured of the confidential and anonymous nature of the information they provided. No names were collected and all possible identifying features have been removed from the quotes used in this report. Prisoners are identified by a number, gender (M or F) and their PMMT status i.e. whether they are on PMMT (stable, voluntarily reducing, retoxing, pregnant); waiting/wanting to start PMMT; removed from PMMT; not wanting PMMT; or are a non drug user. Staff are identified only by a number.

To have provided more information about individual prisoners or staff would have risked revealing their identities.

Organisation of the report

The remainder of this report is divided into six chapters, which address the study objectives. The following chapter examines the evolution and practice of PMMT in settings throughout the world. Chapters 3 – 6 present the findings of this study on MMT in the SPS, i.e. why prisoners want PMMT; why prisoners do not want PMMT; prisoners' views of the processes involved in managing PMMT; and staff attitudes to PMMT. The final chapter discusses the findings and draws conclusions.

CHAPTER 2. REVIEW OF PRISON METHADONE MAINTENANCE

Throughout most of the world, a response to problems associated with illicit injection drug use has been to intensify law enforcement efforts. This strategy has contributed to an unprecedented growth in prison populations (Erickson, 1999). International concern for the health of such drug using populations in prisons has emerged alongside evidence of drug-related harm within these populations. For example, injecting drug users in Bangkok were found to be at significantly increased risk of blood borne virus infection through sharing needles with multiple partners while in holding cells before incarceration. The time spent in these cells was seen as an important opportunity to provide risk reduction counselling and harm reduction strategies to reduce the incidence of BBV (Buavirat et al, 2003). In Berlin, the increased risk of HBV, HCV, and HIV infection among IDUs who had shared syringes in prison was seen as evidence to provide specific preventive action in the form of MMT in prison (Stark et al, 1997). In Spain, Australia and Greece and the USA a high prevalence of drug users and of BBV in prisons has been repeatedly cited as reason to provide harm reduction in the form of MMT in prison. (Martin Sanchez et al, 1997; Crofts et al, 1993; Clarke et al, 2001; Dobkin, 2005; Dolan et al, 1998).

As well as urging for policy to allow commencement of MMT in prison (Watson et al, 2001) there have also been strong arguments against discontinuing MMT that has been started in the community. In Scotland, a study of injecting behaviour amongst a purposive sample of drug-users in Scottish prisons found that factors most closely identified with current sharing of injecting equipment in prison were: (a) having injected a wider range of drugs in prison; (b) frequency of Temgesic use; and (c) being prescribed methadone in the community, then having that prescription discontinued on entry to prison (Shewan et al, 1994). Gruer and Macleod also put across the negative consequences of such policy (Gruer and Macleod, 1997).

Such evidence as stated above increased the urgency of the issue of healthcare for drug using prisoners (Jeanmonod and Harding, 1988; Sperner-Uterweiger et al, 1991).

Methadone maintenance treatment programmes in prison

Despite the presence of international laws and guidelines that call for the protection of the health of prisoners, prison authorities have generally been slow to implement MMT programmes in prisons (Kerr et al, 2004). There are a small number of PMMT programmes worldwide but an even smaller quantity of evidence evaluating such programs.

There are approximately 350,000 imprisoned people in the European Union. A Europe wide survey of different practices on the provision of methadone treatment in prison, carried out in 2002, revealed a mixed picture. Methadone prescription was widespread in Spain and Austria, minimal in Portugal, Belgium, Germany, Ireland, Italy and the Netherlands and unavailable in Sweden and Greece (EMCDDA, 2002; Stoever, 2002). The European Network for HIV/Hepatitis Prevention in Prisons was formed to investigate the current situation including existing prevention policies relating to HIV and hepatitis. The Network identified marked differences between Member States in their policies towards prisoners. Meaningful comparison of different attitudes and approaches to PMMT across Europe was difficult mainly because of the variety found in different countries' policies in this area as well as differences in treatment aims and objectives (Rotily and Weilandt, 2000).

There were three major cross cutting themes that emerged in Stoever's review of methadone treatment in European prisons. The first was that although there was evidence of an increasing adoption of PMMT, detox and abstinence-orientated approaches remained the predominant form of drug treatment available within European prisons. Where prescription methadone did occur, it was more likely to take place within a time limited detox program than a longer-term substitute one.

The second theme was that the practice of discontinuing MMT initiated in the community once an offender was admitted into the prison system was still the norm in most European prisons. In the UK, two-thirds of those on MMT upon arrival into prison had it discontinued on entry to prison. In the Netherlands, of the 28% of prisoners who entered prison on MMT, 96% had it discontinued. A third of registered German drug dependent adults received methadone or codeine substitute in the community, this compared to roughly 5-10% of drug dependent German inmates who received this form of treatment. There was a similar picture in France, where over a

third of those registered as drug addicts received substitute treatment in the community. The number of French inmates who received such treatment dwindled to about 2% out of the 14% of prisoners identified as opiate dependent (Stoever, 2002). Spain was the only country in the European Union where substitution rates inside and outside prison correspond (EMCDDA, 2002).

The third theme was that great variation was found in the areas of guidelines and practical application of methadone programs within prisons across Europe. The UK had no specific national standardised prescription policy or set guidelines that governed the administration of PMMT; Germany was similar. The result of this is that prison doctors in these countries have a degree of therapeutic freedom in the choices that they make, which in turn help shape the specific character of the PMMT program that they work on. By contrast, in other countries with centrally controlled, precise prescription guidelines on methadone, prison doctors had relatively little room to manoeuvre in this regard.

Another example of different approaches in different countries can be seen in the practice of initialising substitution treatment in prison. In France, this was accepted and included within a legal framework, but legally forbidden in Finland and Greece.

As in the UK, other countries also have large intra-country variation. In France substitution treatment for addicts is reported as very unequal from one establishment to another. This is thought to reflect the great variability of the practices of substitution generally and especially the absence of consensus on the methods of adaptation of these practices to the prison environment (Michel and Maguet).

The most renowned in-prison methadone programmes are KEEP (Key Extended Entry Program) at Rikers Island prison in New York State and one in New South Wales (NSW), Australia both of which were established in 1986. KEEP is the only US prison that does not discontinue treatment for opiate addiction at admission.

A recent survey of 1737 other correctional facilities there found that only 19% of institutions funded treatment programs other than detox. (McMillan and Lapham, 2005). Another survey of 500 national jails in the U.S. reported that 12% continued methadone during the incarceration and that very few (2%) of jails provided

continuous treatment to arrested persons on methadone. These practices were considered to jeopardize the health and wellbeing of persons enrolled in methadone programs and underscore the need for uniform national policies within jails (Fiscella et al, 2004). Thus the situation across the United States concurs with the European picture that the majority of prison authorities have shied away from implementing PMMT programs.

However in some countries there are progressive policies towards MMT. Australia has MMT programs that have been well accepted for some time and they have been expanded and liberalised (Byrne and Dolan, 1999). In some regions of Canada, too, there is progressive MMT policy. In British Columbia, continuing methadone treatment had been the standard of care for pregnant women for years but a change of policy in 1996 allowed continuing of methadone treatments for prisoners who were already enrolled in community methadone treatment programs prior to their incarceration. In 2002 a further change of policy allowed initiation of maintenance therapy (Sibbald, 2002).

In Alberta, another region of Canada, however, policy was not so advanced and in 2003 in the right of a prisoner to access methadone maintenance treatment was raised and examined in court. For the first time, a Canadian court ordered that a prisoner be provided with MMT during his or her period of incarceration. As a result of the case, and just before it was to proceed to trial, Alberta changed its policy and now provides MMT to its provincial prisoners - at least when they have been receiving MMT prior to their incarceration (Whitling, 2003).

Evaluation of prison methadone maintenance treatment (PMMTs)

There have been many calls for evaluation of existing programmes (Gore and Seaman, 1996). As in the community, establishing concrete conclusions from evaluations has been complicated by the constant modification of the stated aims and nature of these programmes. In 1996 Dolan et al conducted a review of methadone provision in prisons and reported that implementation of PMMT was likely to offer most of the benefits of community MMT without significant additional problems from adaptation of MMT programmes to the prison environment (Dolan et al, 1996).

Evaluations of the KEEP program in New York State, found that 78% of prisoners on MMT reported for community treatment upon release (McMillan and Lapham, 2005). Multivariate analyses of interview data from New York City inmates comparing methadone programme participants' post release outcomes compared with outcomes for similar addicts who received only a 7-day detoxification while in jail reported that programme participants were more likely than the control group to pursue drug treatment after release and to remain in treatment longer. Although overall rate of retention in community treatment programmes after release was modest, drug use and crime were lower among the programme participants who remained in treatment after 6 months. The in-jail methadone maintenance programme proved most effective among inmates who had already been enrolled in similar programmes before arrest.

The programme in New South Wales (NSW) Australia has been the subject of numerous evaluations exercises (Hall et al, 1994; Dolan et al, 1998; Dolan et al, 1996a). A randomised controlled trial of methadone maintenance treatment there versus waiting list controls demonstrated that heroin use, levels of drug injection and syringe sharing were significantly lower among treated than control subjects at follow up. There was no difference in HIV or hepatitis C incidence (Dolan et al, 2003). Recent research findings on a 4-year follow-up study of a randomised control trial of male prisoners receiving methadone treatment in the NSW methadone programme have shown that retention in MMT reduced mortality irrespective of how long the treatment episode lasted for. This study also found that individuals who received PMMT (uninterrupted) for episodes of eight months or longer were significantly less likely to be re-incarcerated than drug dependent prisoners not on PMMT. Finally, it was found that there was an increased likelihood of HCV seroconversion, “when subjects cycled through short periods of imprisonment or short periods of methadone treatment” (Dolan et al, 2005). These findings, the researchers concluded, strengthened the case for greater efforts to be made to improve the continuity of methadone treatment between community and prison settings.

A study on methadone maintenance treatment undertaken by the Correctional Service of Canada in 2001 demonstrated that MMT has a positive impact on release outcome and on institutional behaviour (Haig, 2003). Decreased drug usage and associated risks as well as decreased incidence of inmate conflicts were reported from a PMMT

programme in Spain (Vegue Gonzalez et al, 1998). Again in Spain, a qualitative study of male and female inmates found improved social and self-esteem, decreased cocaine and cannabis consumption, but increased alcohol, nicotine, benzodiazepine, and designer drug consumption during methadone treatment (Arroyo F, 2004).

If these examples have pointed to a degree of success of these PMMT programs at tackling the issues created by long-term opiate addiction, then why have so few prison authorities sought to implement similar programs (Simpson, 1999). The reason could be that whilst doubts about community MMT have been overcome to some extent by the sheer volume of research work into it, comparative uncertainty about PMMT remains strong because such programmes (and evaluations of them) are scarce. For example, a recent Home Office literature review into prison drug treatment (Bullock, 2003) reported that more work was required to properly evaluate PMMT. The urgency of this task is highlighted when taken in context with an ever-expanding international prison population, a large proportion of whom are drug-dependent individuals with high levels of HCV prevalence and seroconversion (Champion et al, 2004) The issue of HCV seroconversion alone makes it imperative to investigate potential solutions that might tackle the issue, and it is reasonable to argue that the evidence supporting community MMT itself provide grounds for further investigation of PMMT. One approach to further investigation is to seek the views of key stakeholders in PMMT, and ask the staff who help administer PMMT (whose views have at times shaped policy on MMT (Kahn et al, 1978) as well as the treatment recipients what they think.

Providing MMT in prison: staff views

Adequate staffing as well as staff views are important in maintaining any PMMT (Ball et al, 1988). Inciardi and Martin reviewed the history and development of drug abuse treatment in criminal justice settings in the US. Therapeutic communities are described to emerge as the most visible form of treatment in correctional settings throughout the 1960's, but typically were closed in the early 1970's and throughout the 1980's due to prison crowding, and staff burnout, as well as changes in prison leadership (Inciardi and Martin, 1993). This demonstrates what has really been an international reluctance of jail administrators to embrace providing MMT to incarcerated addicts.

Some have argued that the relatively small numbers of PMMT programs established internationally is symptomatic of prison authorities' discomfort with the idea of substitute prescribing. Firstly, prisons were not designed as therapeutic environments. This makes the wholesale importation of a treatment programme that has proved to be relatively successful in the community impractical. Secondly, abstinence based approaches remain more popular than harm reduction ones in the cultural environment of penal institutions. This means that detox, rather than maintenance, is the more common mode of methadone prescription in prisons. Also, prison staff often view PMMT with suspicion. Others suspect methadone as something that provides pleasure for those taking it rather than being part of a treatment programme. Staff have also been described as concerned about the practical implementation of MMT programmes, which they feared might lead to diversion of medication, violence and security breaches (Stoever, 2002; McMillan and Lapham, 2005). The current emphasis on security and abstinence from drugs within prisons is often regarded as incongruent with the goals and methods of harm reduction. Some believe PMMT to be contrary to the ambition of having a drug free prison (McMillan and Lapham, 2005). Prison staff have expressed discomfort at having to operate what many believed to be two divergent policies of aiming to make prisons drug free on the one hand and aiming to help those with drug problems on the other (Keene, 1997).

However Keene's study in the UK also revealed that uniformed prison staffs' views often echoed those of drug dependent inmates. For instance, most staff interviewed supported the notion that individuals with serious drug problems needed treatment. This indicated that the principle of "treatment" for drug dependent prisoners had support amongst uniformed officers. They also recognised that illicit drugs provided a useful and a harmful purpose within prison. For example, some staff believed that drugs such as cannabis and valium could have a positive, calming impact on the atmosphere within a prison. On the other hand officers had concerns about the destabilising effect that the black market in drugs within a prison could potentially have.

In the community, from the outset, difficulties arose with staff of methadone maintenance clinics (King, 1975). In 1976 staff attitudes in a community MMT clinic in the US were reported as ambivalent. In 1972 a community study reported that

methadone maintenance was not yet fully accepted as a long-term treatment by clients, or by the staff that administered such treatment (Brown et al, 1972). In some respects there has been little advancement in some of the prison staffs' attitudes towards treatment aims of MMT since these studies (Graff and Ball, 1976).

In the process of determining how successful community programmes are, staff attitudes towards the clients of MMT programs and staff-client relationships are the two key areas that are examined. Staff's prejudices can stop drug users being able to start treatment and serve to prolong the applicants' illicit drug use and delay their entry to treatment. Staff's negative attitudes toward heroin addicts and toward methadone treatment have been described as the biggest obstacles to providing good treatment. Two studies investigated the influence of methadone prescribers' commitment to abstinence-oriented policies on retention in their maintenance programmes. The more strongly physicians were committed to abstinence-oriented policies, the more likely patients were to be prematurely discharged from their programmes. The abstinence-oriented programmes had worse retention because they generally used lower maximum doses of methadone. Further, abstinence-orientation reduced the beneficial effect of higher maximum methadone doses on retention. This is probably because patients in abstinence-oriented programmes generally receive their maximum dose for only a short period before undergoing a prolonged withdrawal. It was suggested that more attention should be paid to the effect of staff attitudes and beliefs on the effectiveness of maintenance treatment (Caplehorn et al, 1998; Caplehorn et al, 1997).

Negative attitudes were described by Bell to find expression in inappropriate and constricting regulation of treatment, and in inadequate resources to support programmes. They contribute to the ambivalence about the patients in treatment. Such attitudes have been found to find expression in a variety of staff behaviours in anxiety and defensiveness about treatment, in staff ambivalence about the value of methadone, and in extreme cases, in cynical and suboptimal treatment practices. These issues are not merely theoretical barriers to quality, but have contributed to serious problems in the quality and effectiveness of treatment. Bell comments that neither regulations, nor wise prescriptions as to how treatment should be delivered, are adequate responses to these problems and suggest external, peer-based quality

improvement provides an appropriate form of accountability, while enhancing the sense of professionalism of clinical staff (Bell, 2000). As well as the effect of staff attitude, staff–client counselling rapport has also been described as a vital part of the therapeutic process and helps explain why and when treatment is effective (George et al, 2001).

There is evidence that staff attitudes towards the clients of MMT programmes and staff-client relationships also play a vital role in the performance of prison drug treatment programmes (Neale, 1998a; Neale and Saville, 2004). Recent Scottish research that sought to compare the experiences of clients in community and prison drug treatment programs found that a large part of the negative feedback given to prison drug treatment concerned the kind of support they had received from prison staff. (Neale and Saville, 2004).

Clients’ negative sentiments about drug treatment programs are often based on perceived negative interactions with, and attitudes of, the staff (Neale and Saville, 2004). Indeed, one of the key findings of an evaluation of a nascent through care project in a local English prison found that, “prison officers are important gate keepers literally as well as metaphorically” to the successful implementation of any project aimed at helping drug using prisoners. (Mair and Barton, 2001) If prison drug treatments like PMMT are to increase their effectiveness then these issues need attention.

MMT is a combination of health care and law enforcement. In a community study MMT staff are stigmatized from the general treatment community, this also occurs in prisons where addictions prison officers are not integrated well with other prison staff. (Kahn, 1992).

Many members of prison staff began their careers at a time when the traditional Criminal Justice Service position on drug consumption was that it was a cause of crime and a crime itself (Keene, 1997). As drug consumption and injecting increased alongside prison numbers throughout UK prisons in the 1990’s, staff were forced to respond on a daily basis to problems that lay beyond their traditional area of responsibility (Stoever, 2002). In policy terms, the traditional abstinence-orientated stance of UK prisons was modified somewhat by the introduction of harm reduction

policies into prison. As the 1990's progressed, the SPS followed an international pattern of performing an increasing number of what can be termed therapeutic roles alongside their traditional custodial functions. These policy reforms created the much-discussed dichotomy between the twin priorities of control and punishment on the one hand and rehabilitation on the other. Staff, have not always had the benefit of clear top-down communications about aims and objectives of these policies within prisons and as a result have not always clearly understood those aims (Stoever, 2002). If this is the case, it has implications for the delivery of drug treatments like methadone maintenance. In one of very few studies looking at staff attitudes in prison, recent U.S. research reported that younger and non-medical staff generally had negative attitudes towards methadone as a treatment for heroin addiction. Written comments indicated that many staff members had strong and often polarized opinions about drug treatment in a correctional setting (McMillan and Lapham, 2005).

Several steps were suggested towards improving the staff support for methadone maintenance therapy, which included better education regarding opiate replacement therapy as an effective treatment for heroin addiction. Jail staff should fully understand and appreciate the rationale for implementing MMT; more staff training would be required to achieve this (McMillan and Lapman, 2005). This is one call of several for improved training for those involved in methadone programmes.

Staff Training for MMT

In the community literature there is a pattern of different attitudes to methadone in staff who have received different levels of training. Senior staff, with more formal training generally reject abstinence-oriented policies while nurses and counsellors tend to support them (Caplehorn et al, 1997). Individuals with more formal training have also been reported to be less supportive of confrontation and more supportive of the increased use of medications. (Forman et al, 2001). A questionnaire survey of 112 counsellors in 14 publicly funded methadone clinics in New York City was conducted to determine personal backgrounds, counselling process variables, attitudes concerning addiction and treatment policies. Correlates of counsellors' attitudes were also identified: (a) abstinence-oriented counsellors were more likely to be younger and without supervision responsibilities; (b) stricter attitudes about treatment were shown by female counsellors; (c) medically incorrect opinions were associated with

less time employed. It was concluded that these patterns of attitudes should be the focus for more and improved staff education and training (Magura et al, 1997).

However in one paper Caplehorn et al report that there was no significant correlation between staff's knowledge of the benefits of methadone maintenance and their support for abstinence-oriented policies. Staff who endorsed policies that enforce abstinence and limit the duration of maintenance were generally found to have a personal disapproval of drug use (Caplehorn et al, 1996).

Research evidence has suggested that one of the root causes of prison staff's unease with implementing more recent harm reduction policies alongside more established abstinence-based policies was the lack of a well thought-out training about the former (Keene, 1997; Stoever, 2002; Wilcox, 2002). Uniformed staff were not alone amongst prison staff in this regard. Writing about the level of relevant training received by prison nursing staff on these issues Wilcox observed, "there is no recognised accredited qualification for a specialist prison nursing role. Induction programmes do not exist in all institutions, and continuing professional development occurs haphazardly according to the individual nurse, with little evidence of strategic planning in order to meet the health needs of people in prison". (Wilcox, 2002)

Drug users' views on drug treatment evaluation

In 1978 Stuker et al suggested that addict opinions represented a valuable source for evaluating treatment approaches and identifying self and staff perceptions of therapeutic significance (Stuker et al, 1978). However little research was done in this regard until client input into UK public services grew in importance following the establishment of the patients' charter in 1991. This charter outlined ten basic patient rights and popularised the use of consumer type surveys to illicit their views as drivers for service improvements (Jones et al, 1994; Neale, 1998b). In keeping with this trend, drug service users' views began to be sought out and used to inform improvements in community based drug treatment programmes. Research in this area has shown that the views of drug dependent individuals are based on an "intrinsic database of drug experiences" and are a "valuable resource in planning services" (Michon quoted in Montague, 2002; Jones et al 1994).

A few qualitative studies of drug users in the community have been performed. In a community-based methadone programme in Victoria, Australia, the majority of clients were satisfied with the programme and the services delivered by dispensing pharmacies and prescribing doctors. Another survey in Spain showed that Spanish clients were slightly satisfied with conventional centres, although they failed to detect specific variables that they could strongly relate to that satisfaction. Interestingly the views of a prison sub-sample of that study was excluded from overall analysis because survey acceptance and satisfaction was very different in prisons than in the other centres. No further details were given.

There is very little in the literature on drug users' views on staff in methadone clinics, however, one UK community study which asked service users to describe their "ideal" methadone programme, reported that respondents wanted individuals with personal experience of using drugs to fill key staff positions within an MMT programme (Jones et al, 1994).

Studies eliciting inmate drug user views are rare, an extensive literature review has produced merely a handful, but none of them are expressly considering inmate drug users' views on staff attitudes. With respect to prisoners' views on staff in prison dealing with addiction issues no directly pertinent studies could be found.

Staff of the Research and Statistics Division of the New South Wales (Australia) Department of Corrective Services monitored the New South Wales Prison Methadone Program from mid-1986 until the end of 1991. Typically, inmates reported that the methadone programme had benefited them. They stopped hustling for, using, and thinking about heroin; felt less aggressive; and were better able to adjust to prison. Of those reincarcerated following release on the programme, 87 percent reported that methadone helped them reduce or stop using heroin. However, on most of the measures of reoffending used, those on the methadone programme did not perform significantly better than those in the comparison group (Gorta A, 1992). In a study in an Irish prison, prisoners were reported to view their time in prison as an opportunity to address substance misuse related problems. Long et al implore health professionals to recognise the genuine intentions of some drug users in prison and not miss this opportunity (Long et al, 2004).

Writing about prisoner views' of methadone prescribing in an English prison, Hughes stated that, "the value of this approach lies in ability to analyse the stated claims of policies and practices against the experiences of people they affect" (Hughes, 2000) Acknowledging the value of this approach, the SPS formally recognised the need for prisoner feedback into treatment delivery within its "Partnership & Co-Ordination" document and this research may be seen as part of the SPS's continuing commitment to improve service delivery.

CHAPTER 3: WHY PRISONERS WANT PMMT

“There are some lassies that are on it the now that do want to make a go of it, ‘n’ kind of come off drugs. There’s other lassies that . . . maybe don’t think they could ever, ever cope withoot anything, ‘n’ that’s why they take methadone, ‘n’ they’ll maybe be on that for a long, long time before they even think about goin’ tae the next stage. Then there’s lassies who just take it for a square up, until they get something else.”

(F008 – not wanting methadone)

The quotation above introduces the spectrum of different reasons given by people wanting methadone treatment in prison. Reasons differed between individuals and ranged from a desire to stop drug use to a varied and complex mesh of factors. Five main themes clearly surfaced during interviews: i) methadone provided a route away from the negative consequences of prison drug use; ii) it provided short term practical improvements to the lives of those on the drug; iii) methadone assisted in longer term motivations to cease drug use; iv) methadone was used to supplement or otherwise help users continue their illicit drug use and, finally, v) indecision about wanting PMMT.

The large majority of drug dependent study participants who talked about PMMT positively mentioned the immediate and short-term benefits that PMMT gave, or potentially gave them, and these are discussed in the first two sections of this chapter. A minority of the sample talked about PMMT playing an integral part in an attempt at a long-term transformation of their lives away from drug use and the responses given by these participants make up the third section. The fourth section looks at those who used methadone as an “insurance” measure, to supplement the erratic supply of heroin. The fifth section covers those responses that revealed a degree of uncertainty about PMMT.

A final section considers any differences in the viewpoints on these themes between and males and females and between short and long term prisoners.

Route out of the negative consequences of drug use

For the great majority of respondents who wanted, or were on PMMT, methadone maintenance represented a route away from the negative consequences of drug use in prison. Across the study group there was consensus about the nature of what these problems were: erratic supply of drugs, debt, violence, mental and physical stress, and the effect on the individual's family. A minority referred to the impact PMMT has on reducing injecting behaviour and the threat of blood borne virus transmission and some mentioned the punitive action from prison authorities if caught using drugs as an incentive to start PMMT.

The potential difficulties that habitual illicit drug use in prison created were numerous and often had implications for prisoners' families as well as the prisoners themselves. By understanding these problems in greater detail it is clear to see why, for many respondents, PMMT was an attractive option. The negative consequences of "*chasing a habit*" in prison were part of everyday life for drug using prisoners and often the accumulative effect of these acted as a powerful stimulus for prisoners to want PMMT. Its greatest strength was the daily stability that it brought and this appealed to many drug using prisoners especially when they compared it to the uncertainties characteristic of the regular pursuit of illicit drugs in prison.

Erratic supply

The vast majority of prisoners in the study group agreed that the business of obtaining illicit drugs in prison is a far more difficult and complicated process than sourcing them in the community. One prisoner succinctly summed up the difference,

"Outside it is different. You can just go anywhere, and get it, you could get a charge outside like that (snaps fingers) if you wanted a charge. But in here it doesnae work like that."

(M001 – on methadone)

Respondents described a delicate balance of funding, cooperation and collaborative social networks both inside and outside the prison that facilitated illicit drug use in prison. This reliance on multiple interlinked factors often meant a greater potential for things to go wrong.

“I think the pressures of it are worse in here, because . . . it’s harder to obtain. Outside I wouldnae wake up every morning worrying about where I am going to get a fix fae. In here, fae the first time, I worried about it because of the supply . . . Ma whole day in here revolved around nothin’ else, except chasin’ a charge until I got on the methadone.”

(M003 – forcibly removed from methadone)

Debt

The difficulties of getting heroin into prison resulted in an inflated price for prison heroin. Most prisoners made the point that the average size of a bag of heroin in prison was significantly smaller than the equivalent outside prison; this reduction in the average size of a bag was not matched by a reduction in the price. A commonly made observation was how costly the regular use of illicit drugs in prison was.

“I had some money in the bank before I came into the jail, but I’ve no money now, I’ve used it all on drugs, just to keep me pain free.”

(F008 – forcibly removed from methadone)

Unsurprisingly, drug related debt was commonly reported and a major factor for those wanting PMMT. This remand prisoner summed up a common sentiment when he commented that being on PMMT:

“would save me a fortune.”

(M020 – wanting methadone)

Another prisoner stated:

“Most of the guys I ken that have gone on methadone, [it’s because] they cannae afford heroin.”

(M024 – not wanting methadone)

Violence

Most respondents directly linked the majority of violence in prison with drugs, or rather with the breakdown in the supply of drugs.

“If you have got a habit and you don’t know where your next tenner is coming from the next morning, you don’t know where your next charge is coming from the next morning, then you are a very unpredictable person. You can that way of thinking “I have not got a tenner for the next morning what will I do?” That could turn somebody into a very dangerous person, somebody that isnae usually dangerous.”

(M015 - wanting methadone)

The blend of uncertain supply combined with high prisoner demand for drugs contributed towards a pervasive atmosphere of tension and eruptions in interpersonal violence. One prisoner recalled a recent violent incident caused by the arrival of a parcel of illicit drugs not matching one of the recipient’s expectations.

*“[A] guy got slashed the other day [with] a double razor right doon the face the parcel was meant tae be . . . an 8th and there was only about 2 gram . . . so ***** ended up gettin’ ***** slashed and noo he’s lying up in the surgery with a big slash fae the rest of his life . . and the other guy’s in the digger. Its just silly, that’s just the way the jail runs.”*

(M008 – on methadone)

Stress

The combination of these factors contributed towards high levels of stress for drug using prisoners.

“You are always setting yourself down for falls...your always at high-doe waiting for it to come in, chasing people to get it and if they don’t get it your depressed...it’s really more hassle than it’s worth . . . you get really, really stressed through it.”

(M018 - not wanting methadone)

“You wake up in the morning, you’re either worryin’ about whether somebody’s getting’ a visit that day [or] you’re just thinkin’ about the next day, you’re thinkin’ a day ahead all the time, ‘n’ the day after that. If the visit is happenin’ you get up, go to your work, cause you know it’s only gonnae be a couple of hours because you’re gonnae be sorted, then when you come back fae your work ‘n’ see somebody didnae get a visit, or somebody’s visit’s fell through, ‘n’

that's you, you're just on a downer all day, 'n' then you know that you've got to be up all night, rattling."

(F005 – on methadone)

Some drug dependent prisoners also talked about another form of anxiety, that caused by hiding their drug use from their family and friends. These prisoners commonly shouldered the combined struggle of having to simultaneously support drug use inside and maintaining the pretence of being drug free during visits with family members. As one prisoner commented:

"My girlfriend thinks I've really screwed the nut [and] that I'm aff of everything cause she knows the problems that it's caused. I canny tell her."

(M007 – wanting methadone)

The stress experienced manifested itself in a variety of ways: for some it was physical. One respondent described the physical manifestations she suffered the night before a potential delivery of drugs:

"Ye get agitated and all that jist thinkin' about it, it's weird, sweatin' 'n' all that, . . . waitin' on these visits. It's dead, dead funny. . . Oh it's in your heed fae the night before. Sometimes you're gettin' a broken sleep just thinkin' about it."

(F009 – wanting methadone)

Sleep deprivation was the most commonly reported physical side effect of this stress; sleeping problems were exacerbated both by heroin withdrawal and the doubts about whether or not an expected package of heroin would arrive successfully.

Others talked about psychological stress.

"Knowing that there's drugs in the hall and your in such a small space and you know the drugs are in, it's . . . torture at times knowing that there are drugs in the jail and you cannae get them..."

(M014 – wanting methadone)

For many prisoners, the first benefit that methadone provides is relief from the anxiety described above. One prisoner compared her mental state between using heroin and being on methadone:

“Wan minute you’re up and you’re on a high, and then the next minute you’re doon low and depressed ‘n’ you’re up ‘n’ doon all the time whereas being on the methadone it stabilises your mood all the time.”

(F005 – on methadone)

Family and friends

The pressure caused by prison drug use was by no means confined to drug users. By asking family and friends to acquiesce in the supply of illicit drugs into prison, drug dependent prisoners placed great pressure on often long-standing relationships with people outside prison. One prisoner described the corrosive effect repeated requests for money had on relations between drug using prisoners and their family and friends in the community:

“If you’re a user, . . . everything is all geared towards scoring all the time, so your relationships break down, . . . ‘cause your always on the phone wanting money aff people . . . so you end up burning all your bridges with people, . . . it’s worse in here because you cannae do anything fae yourself, . . . you’ve got to get the money aff someone . . . so, you use all your family and use everyone round about you.”

(M032 – on methadone)

Family and friends of drug using prisoners are involved in two ways: the majority of drug dependent respondents relied first and foremost on close family and friends by asking them to actively pay for and import drugs themselves or to “send-on” money to a third party in the community which would then allow the prisoner to purchase drugs in prison. Prisoner attitudes to making such requests varied greatly. They ranged from those who appeared to be comfortable with making these demands, to those who were ill at ease at the inconvenience and stress they caused, to those who refused to involve their family in supporting prison drug use. According to prisoner testimony, family reactions at being asked to perform their function varied widely. One certainty was that family and/or friends’ co-operation was an absolutely vital part to sustaining

regular drug use during incarceration and/or avoiding physical harm that often resulted from the non-payment of drug debts. Refusal to cooperate, however, could result in drug cessation in prison. One prisoner reported that he ceased to use drugs altogether following a family member's decision to cease to supply him.

“He . . . wouldnae gee me when I was inside the last time. (he) refused tae keep me going while I was there.”

(M034 – wanting methadone)

If the drug dependent prisoner's family did decide to collaborate the consequences often placed overwhelming pressure on them,

“Its all about families as well, cause like they're suffering when he's on heroin in prison, I mean that's a fact ... because they're having tae pay his habit, wan way or another; they're sending money tae some address, and I know people who go on phones tae their granny greeting and crying tae get money oot them. Your no' talking about £10 a time your talking about £50 and £100, which is a lot lot a money tae some people ootside, well tae maist people outside, .. it's not just about the prisoner, it goes a long way back, causes a lotta pain.”

(M007 – wanting methadone)

Harm reduction

Although it was not a predominant issue, a sizeable minority of drug dependent prisoners spoke of the impact of PMMT in tackling injecting behaviour in prison. Those respondents who brought the subject up during interview made a connection between the introduction of PMMT and a reduction in the overall levels of injecting in prison. Most who mentioned this preferred to talk in more general terms about what they had perceived as a reduction in prison injecting rather than their own personal experience.

“Seven years ago . . . there wis a lot mair injectin' in prison then. People sharin' needles . . . ye're talkin' hundreds of guys that've caught hepatitis C in prison through jaggin' . . . giving [prisoners] methadone an' that, that's cut a lot of that oot . . . years ago you'd go intae a cell an' there'd be ten, twelve people in it all usin' one syringe . . . one after the other . . . noo, there's a lot of guys . . . that are on meth that arenae jaggin', so, y'know, for that reason . . .

it's good... I mean, if people with hepatitis C arenae jaggin' an' sharin' their works with other people, they're no' gonnae spread [HCV]. It's harm reduction isn't it?"

(M026 – on methadone)

"People taking methadone will take injecting oot the equation...maybe have a wee smoke noo 'n' again but they don't feel the need to push themselves as far doon as jag again."

(M018 – not wanting methadone)

A few prisoners talked specifically about how their most recent methadone prescription in prison stopped them injecting.

"Methadone's stopped me fae injecting, I've never injected since I've been given meth . . . so that's the most positive thing that's come oot it for me anyway . . . It's changed my life, around I could say."

(F002 – forcibly removed from methadone)

Fewer still directly mentioned their fear of contracting blood-borne viruses when they talked about their reasons for wanting PMMT. One prisoner revealed that finding out he was hepatitis C positive, something he directly attributed to sharing needles and syringes in prison, did not stop him continuing intravenous drug use but a fear of contracting HIV had forced him to ask for help.

"The reason I want to start methadone is because . . . I have been injecting every day basically since December. . . And I am not talking my ain set of tools . . .I'm talking about sharing, [I'm] paranoid. Getting more paranoid as the weeks have went on. . . . And it is getting worrying now . . .I actually think I have got the virus"

(M027 – wanting methadone)

Another prisoner admitted that such was his eagerness to inject, his cleaning of a set of needles and syringes previously used by someone he knew was HIV positive was not always as thorough as it could be.

“I was injecting ... [with] my partner in here, my best friend has got the virus [HIV] . . . and I am hep C myself, . . . I knew it was just a matter of time before I caught it, being in such a hurry when I wouldn't clean them right and I knew that . . . it was on the cards, it was inevitable and I knew it was gonnae happen and I decided there and then that I needed help. I need to get off this I need something or that is what is going to happen.”

(M030 – on methadone)

Prisoners did not go as far as to say that injecting in prison was now a historical phenomenon. Indeed, some argued that because of the difficulty of regular supply and reduced amounts of illicit drugs coming into prison, injecting remained an attractive option for a minority of prison drug users. Talking about her mindset whilst injecting in prison one prisoner added:

“You don't think . . . what's the dangers . . . what's the outcome . . . gonnae be? ... when you're rattlin' . . . all you're really thinking about is you need a hit, that's it.”

(F001 – on methadone)

She later acknowledged that PMMT had contributed to her ceasing her injecting practices.

A small number of respondents reported knowing of previously non-injecting drug dependent prisoners who wanted PMMT and who simulated or began injecting because they believed that the physical marks of injecting would strengthen their case.

“That is something else. You have to show you've done drugs. So if you werenae a jagger [injector] and you wanted methadone, you had to have track marks. Well guys who would never think of jaggging, had to jag . . . how can I put it? 75% jag and maybe 25% sat with a needle doing wee bits of damage”

(M010 - not wanting methadone)

Punitive measures

The negative consequences of prison drug use emphasised least strongly by respondents were punitive measures resulting from illicit drug use. This is not to say that prisoners did not acknowledge that these punishments had an effect on them.

However, when drug dependent prisoners mentioned disciplinary action against them it was presented as something that caused a subsequent knock-on effect on their precarious supply of drugs. Respondents rarely mentioned disciplinary actions alone as a motivation for wanting PMMT; it was only ever talked about as one of multiple factors that precipitated prisoners' attempts at getting a place on a PMMT programme.

Short term/practical motivations for wanting PMMT

Beyond the desire to move from the immediate negative consequences of a drug use were a group of what can be termed more positive short-term reasons for wanting to go on PMMT. Many of the study group were either on PMMT or wanted to be on it because they believed that it would improve their quality of life in prison. There was a consensus that PMMT introduced greater stability to the lives of those prisoners on it. There was also agreement that with this stability came the opportunity for individuals on PMMT to start improving their daily prison life and many of those interviewed wanted to and did use PMMT as a foundation from which to do that. Methadone maintenance was an attractive option for many because it allowed them to stop craving illicit drugs; to continue a community methadone maintenance treatment (CMMT) programme; gave them time to reflect on their lives; to improve family relations and visits; to aid sentence management and, ultimately, to help an individual's progression through the prison system.

Stops craving

The majority of those who were either on methadone maintenance in prison or waiting to get on it credited it with making improvements to quality of life in prison. Even many of those who did not want PMMT acknowledged that it provided tangible benefits to those on it. Methadone's chief attraction to those who wanted it was that it was seen as something that could stop the craving for illicit drugs. For those wanting to start PMMT inside, the most common and, sometimes only, expectation they had about PMMT was that eventually it would / did enable individuals to stay away from drugs.

“It would stop the craving fir taking illegal drugs in here...it would also keep ma sleep pattern together 'cause I wouldnae be craving fir the heroin...”

(M014 – wanting methadone)

Staying off drugs was the first and most important goal that methadone made possible for drug users to accomplish. .

Continue CMMT

The continuity between community and prison methadone treatment programmes for those who had not used illicit drugs on top of their community prescription was widely recognised by the study group as a welcomed step forward in prison drug policy. More often than not, the first issue that those prisoners who continued a community prescription inside mentioned was that PMMT meant that they did not need to pursue illicit drugs in prison.

Time to reflect

Most agreed that the pursuit of illicit drugs in prison was an extremely time and resource consuming process. One of the results of going on PMMT was that it had the effect of freeing up lots of time because it largely eliminated the need to pursue illicit drugs. These individuals reported that as a result of this they had more time and space to think more clearly about their personal situations. One prisoner spoke about his changed priorities once he was on PMMT:

“Ma thoughts were towards mainly me [when he used heroin in prison], noo I think about ma family.”

(M011 – on methadone)

Another stated:

“I think a lot clearer and different [about] . . . lots of different issues: the kids, housing, family, things I have to deal with outside that I wisnae dealin’ very well with when I was on heroin.”

(F003 – on methadone)

These comments were fairly typical of those on PMMT, with many using the stability that PMMT provided them to turn their attention towards often damaged family relationships.

Improve family relationships

Desire to improve family relations in the short term was one of the major reasons given by prisoners for why they wanted PMMT. Clearly, asking families to be involved in supporting prison drug use damaged family relations; because of this many prisoners viewed methadone as the best and quickest way that they could lessen the burden on family and hope that this step would mark an improvement in family relations. One prisoner's story illustrated just how family concerns could precipitate the desire to start PMMT and leave prison on a methadone maintenance prescription. Recalling the period prior to him being stabilised on PMMT, he remembered that he was solely concentrating on the pursuit of illicit drugs whilst his mother took responsibility for his children. However, after his children were taken into social work care when his mother was no longer able to look after them, he shifted his focus onto regaining custody of them. It was during this time that he began requesting PMMT. When asked about what factors lead to him starting to ask for PMMT he responded:

“The social trying to take away my kids. . . and all the friends I have lost in the past through drug use, ken? Some of things that I have done to keep a drug habit . . . and the life style that went with my drug habit. I think it was mostly my kids, the fact that I am losing my kids, the fact that I lost ma partner right? And the way that some of ma family look at me, the way they think about me, things I have done in the past.”

(M001 – on methadone)

This example illustrates what a critical role family relations often play in decisions to take the initial steps to addressing a drug problem in prison. Another prisoner recalled how a family member was imprisoned as a result of helping him support his prison drug use:

“He ended up in court for giving me a parcel on a visit, gave him two years for it. He has a wife and weans, he got caught passing a parcel. That just shattered me, I am going to knock this on the head go on methadone.”

(M010 – not wanting methadone)

Continuing to use illicit drugs in prison often had a negative impact on visits, such that some drug using prisoners chose to avoid visits altogether.

“A lot of guys willnae go tae visits because they don’t want to get [to] the visits in that state, full of drugs and them [family] seeing them [prisoner] looking bad”.

However methadone could drastically effect improvements in prisoner and family relations.

“When you start on the methadone you see guys starting to take visits with their family cause their starting tae look good again, and they’re feeling good.”

(M028 – forcibly removed from methadone)

Not all drug dependent prisoners had breakdowns in family relationships but there was a common feeling that being on PMMT did lead to improved family interactions at visits and that this was a real bonus for prisoners because visits were valued for the family contact they provided.

“It’s brilliant, mair relaxed. I don’t need to worry about who’s grabbin’ me by the throat, trying to stop me swallowing anythin’, it’s ... I can sit and enjoy ma visits now.”

(M016 – on methadone)

“When I was on it [PMMT] I got visits when we were all holding hands an talking, now [having been removed from PMMT] it’s just a completely different visit.”

(M033 – forcibly removed from methadone)

One young female prisoner explained that being placed on closed visits fuelled her fear of losing contact with her parents and that, in turn, motivated her to try and get on PMMT.

“Trying to explain to my ma and da I am on closed visits again and they are like that “see if I find it is through drugs we are not coming back to see you”. So there is a chance I am going to lose my ma and da through this.”

(F013 – wanting methadone)

This prisoner's concerns highlighted the fact that different families reacted in a variety of ways to the knowledge that their relative was drug dependent in prison. To avoid negative reactions some prisoners hid their drug use from their family and friends; others preferred to claim that they were drug free during their sentence. As a result, a prisoner revealing to his / her family that they were on PMMT was not always welcomed as a progressive step by that individual's family. One prisoner illustrated the difficulty that some prisoners face in this regard.

“[There is a] guy who is tearin’ his hair out. [his family] . . . think he’s conquered the drug problem . . . he’s possibly going for the methadone, which he disnae want tae dae because his family’s totally against it. They think he’s clean . . . [it’s] not every family that’ll tolerate [PMMT].”

(M029 – not wanting methadone)

Although not all prisoners reported that their families welcomed PMMT, the majority of prisoner accounts talked about PMMT as having a positive effect on their family relationships; something that for most allowed a shift in emphasis during telephone conversations, letters and visits from their needs and concerns as a drug dependent prisoner to the wider concerns of the family.

Sentence management

There was consensus across the study group that regular use of illicit drugs in prison was not conducive to regular and full participation in prison programmes, such was the focus on acquiring drugs. This created a kind of inertia effect for many drug dependent prisoners that often dislocated them from everyday work and education programmes. One prisoner described her attitude towards work and education prior to her being started on PMMT:

“When these classes . . . [were]. . . on I’m lying rattlin’ and the last thing you want to dae is get up and go to your work or go to a class . . . I’ve not took any skills classes or painting classes or . . . education because I’ve got a drug habit and I don’t know one day from the next . . . I live each day as it is.”

(F005 – on methadone)

Within this context, another short term benefit that prisoners' associated with PMMT was that it was seen to help prisoners make progress within and through the SPS

system. Advancement in this sense was measured by benchmarks such as moving into a “better hall”; reductions in disciplinary offences; courses completed; obtaining a lower security category; and eventually transfer to open conditions, parole and beyond.

There was a clear connection in prisoners’ minds between being on PMMT and being better able to achieve these small progressive steps within prison. However, different approaches emerged when prisoners talked about using PPMT as part of their sentence management. All prisoners who wanted or were on PMMT looked on it as an opportunity but there were a range of different expectations of what that opportunity might lead to amongst prisoners.

Some spoke about it helping them because it made them appear as if they were “playing the game”. In other words, it gave them the appearance of doing something about their drug dependency that in turn (it was hoped) would help them achieve more favourable parole conditions and ultimately to gain their liberty quicker. One prisoner recalled the change in his attitude toward PMMT after months of actively pursuing illicit drugs in prison. Upon arrival in the long-term prison and with his release date approaching he admitted that, for him, PMMT’s chief appeal to him, other than helping him avoid heroin, was that it placed him in a better bargaining position to push for a reduced parole period in the community.

“It is time to move on through different prisons. Time to make them see that I am playing the game basically to try and get a move to open conditions . . . Put it this way if I never went on the methadone I would probably still be stuck in the second flat in D hall . . . It got me out the eye of the officers when I wasnae taking . . . so what it has done it has . . . got me not noticed any mair, put me through to a different hall. “Because he is on his methadone noo he is doing OK. We will let him try this.” So it got me that . . . I don’t really like methadone, know? . . . I don’t think it will bring out my good side once I am outside. The access I have got to drugs, I can get as many drugs outside as I want. In here it is different I canny get it, not as much access so I have got to be content with what I can get . . . It is making me, it is like playing a game in here.”

(M004 – on methadone)

His motivation for wanting PMMT confirmed the view of some cynical prisoners, who often held anti – PMMT views, who maintained that, far from being about the long-term transformation of drug users’ lives, methadone maintenance in prison was simply about achieving more comfortable conditions for those on it until their release. This perspective does not accurately represent the motivations of the whole group of prisoners interviewed. One female prisoner talked about PMMT as being:

*“A good thing, because I’m no’ getting slammed [on] reports . . . the mair reports you get the mair f**ked up you get cause ye cannae get your home lease, right Up until a week ago, and I’ve been in 11 month, ‘n’ I was the high category up until a week ago there . . . I’ve been removed from a high to a medium noo . . . cause I’ve got my act together, because I’m no runnin’ about mad. . . .because of ma methadone . . . its quietened me right down.”*

(F001 – on methadone)

Moreover, she did not simply acknowledge PMMT as a platform from which she could to reduce her security category. She also credited it with preventing her from contracting blood-borne viruses (she had been regularly injecting in prison), providing her with the motivation to go to work and education and an increase in her self esteem. She valued the reduction in her security status that brought her closer to home leaves as just one of many benefits that the stability afforded by PMMT brought her.

Many prisoners talked about methadone maintenance being a platform from which they were able to better utilise what the prison system had to offer. They wanted, to a varying degree, to use this stability to help them, in their view, to use their time in prison more constructively. For most of these prisoners this meant either taking part in and / or deriving something more out of work, physical training and education. The majority of those on or waiting to go on PMMT explained that being on methadone maintenance greatly improved their ability to regularly attend all the programmes that the prison service offered them.

The combination of structured activity and PMMT helped many to cope with their cravings for illicit drugs and often led to positive transformations in the day-to-day life of drug dependent prisoners.

“If I wisnae on methadone I wouldnae be daeing any of these things, I wouldnae be going to education, I wouldnae be thinking about going tae college, I wouldnae be going to PT, a wouldnae be working, I’d be too busy chasing things about the hall . . . Like a heidless chicken.”

(M012 – on methadone)

After a period of stability and routine, some prisoners could harbour more aspirational aims for the remainder of their sentence.

“I would like tae improve on a lotta things, education that I didnae dae when I was younger, the PTs, (physical training) improve my art. The work sheds, there is a lotta . . . sheds you can get certificates in . . . there is quite a lotta things that fill your week up. With you being certain and steady, the weeks fly by . . . When you’re on heroin, you’re full of great intentions, you’ll say you’ll dae this dae that . . . when your not on heroin and, like myself on the methadone, I’d like tae take advantage of everything that’s there fae me and I . . . learn a lot mair things.”

(M002 – on methadone)

When asked about why she was putting herself forward for consideration for PMMT, another prisoner pointed to the progress made by her peers.

“They’ve got that wee bit of stability, they’re takin’ classes, they’re takin’ education, takin’ parenting classes to move forward with their kids, ye know stuff like that . . . when these classes are on I’m lying rattlin’.”

(F005 – on methadone)

A common pattern of behaviour was that, once stable on PMMT, prisoners tended to favour attending work and physical training over education and other cognitive behavioural programmes. There was a sense amongst those on PMMT that the prison service still had some room to improve the range of courses aimed at drug dependent inmates.

“[When] you are on methadone you are not on a programme, there is no programme about it. You are getting up in the morning and going to get meth

then they are leaving you . . . 'til the next [day] . . . that is not a programme. A programme is something that is scheduled . . . there is nothing structured about methadone . . . What they should be doing is . . . geeing you methadone because you want . . . to evaluate your drug use, . . . evaluate your life in using, [PMMT should be] a means to an end, to get clean, a stepping stone . . . once you start on the meth they should be showing you the next stepping stone, counselling whatever, dealing with the problems . . . maybe start doing compulsory addiction courses, compulsory . . . NA courses. . . . all the wee things but if you put all the wee things together you do get somewhere know what I mean? . . . it kind of plants the seed in people's heids to know what route to take to . . . change."

(M015 – wanting methadone)

Prisoners who had had previous experience of “drug courses” in prison had a variety of criticisms about them. Some denounced the courses on the basis of what they saw as credibility issue.

“The people who were doing (the courses) they had never had a charge . . . I used to say to them “ever smoked a joint”? No, so what can you tell me about drugs?”

(M006 – not wanting methadone)

Others pointed to what they saw as a counter intuitive structure imposed on attendance at these courses.

“There's two drug courses in this prison. A drug awareness course, I think that only lasts fae a couple of days, and they've got what's known as a drug relapse course. People on methadone cannot get on the drug relapse course which seems silly . . . the whole point of putting me on methadone is tae stabilise me an keep me away fae a chaotic lifestyle of using drugs. But I'm still in the danger of relapsing so . . . surely some sort of programme should be introduced tae help protect me fae relapsing.....but if I'm on methadone I cannae get on this programme.”

(M003 – forcibly removed from methadone)

Not all prisoners chose to take up the option of going to work or education once they were on PMMT. The prisoners on PMMT who took this attitude represented a minority in the study group.

When this approach was adopted, it was resented by other prisoners.

“[Being on PMMT takes] them away from the normal routine of prison, getting up going to work. Once they're on that methadone they don't have to do anything.”

(M023 – non drug user)

Social interactions

When prisoners spoke about those who had recently started on PMMT engaging or otherwise with work and education programmes, they also pointed out that this step was often accompanied by a rearrangement in their patterns of social interaction; the social interactions of prisoners who were actively pursuing illicit drugs were noticeably different than the social interactions of those on PMMT. To understand why PMMT often modifies the relationships of drug dependent prisoners it is important to look at what drives the social interactions of those prisoners when they are predominantly concerned with the pursuit of drugs.

There was a general agreement across the study group that the regular pursuit of illicit drugs in prison was greatly aided by a collaborative network of like minded drug users. By pooling their resources in terms of finance and the co-operation of family and friends in the community, each member of the group aimed to receive parcels in a staggered fashion so that the group could take illicit drugs as often and as consistently as money and circumstances allowed. Prisoners referred to these mutual groups as “camps” and they were seen as an expedient method of overcoming the challenges of maintaining a regular supply of heroin into prison.

“Usually you get camps . . . in the jail that is what they call them, certain wee groups and I would take my turn in getting the powder [heroin] in and my pal would take his turn in getting it in. There would be no more than two or three and through that wee camp you would all survive, getting enough for yourselves . . . That is the way it went.”

(M030 – on methadone)

Equally important to these prisoners was avoidance of attention from prison staff and that usually meant an emphasis on avoidance of interaction with staff altogether.

“When you are on heroin you just want to stay away from staff. You don't want to get caught, your eyes show it . . . I have blue eyes . . . It is obvious when I am on heroin.”

(M031 – on methadone)

For some on PMMT, a key component in making a successful transition from habitual drug use to stability on methadone was to modify their social interactions with other drug using prisoners.

“If you stay away fae the wans that's got the smack you can have an excellent methadone programme [in prison].”

(F004 – on methadone)

This action usually resulted in increased social isolation for those seeking to avoid triggers that might lead to them relapsing.

“The thing that gets me, see if I walk into a cell and someone's smoking heroin . . . the smell will hit me . . . that's when I start getting the bite for it...it's like an instinct when you smell it, a primal instinct ... you just try and no' get yourself into they situations.”

(M018 – not wanting methadone)

The wish to avoid temptation of using heroin motivated this prisoner to change her social circle.

“I've chose to drop all the pals . . . a lot of people I've used with . . . and I have had a lot of stick . . . they see me at a stage where they're not . . . they see me getting on and getting qualifications and they're still in the other end of the jail and I'm at the top end, and, I don't know, basically it's jist yer not the same person because I've broke away from the whole drugs circle . . . I'm not the same person, I've changed for the better I think . . . when I went on the meth I was still sort of like involved with some of them and I shared a room with one of them and then it was coming to blows because I was wanting different

things I wis on my methadone, she was sitting taking kit in the room and I was like “don’t dae it” . . . so I had to go to the staff [and say], look you have to move me on or it's going to end up being holy murder in the room because I don’t want to be about that kind of stuff, I couldn’t deal with it at that time when I'm trying not to take it.”

(F014 – on methadone)

Discussing which prisoners on PMMT were managing to avoid using heroin, one prisoner claimed that you could identify those prisoners because they were estranging themselves from their previous social group.

“They’re wans that . . . keep to themselves basically...no abusing it.... you’ll see them just standing at the balcony looking over . . . they’ve lost interest in what's happening round them in prison, that sounds like a bad thing but it's really a good thing...it's a rat race [pursuing illicit drugs in prison] really... [and they are] separating themselves from the rat race... they’ve seen the light.”

(M018 – not wanting methadone)

Not everyone shared or approved of this approach.

“When you are in prison you hae the guys that you will sit with and the guys you willnae sit with. It doesn’t matter whether they take methadone or not.”

(M024 – not wanting methadone)

“It (PMMT) does that to people . . .shy away from their pals I think that is a bad thing Because it is making people lose their personalities.”

(M004 – on methadone)

Whilst it cannot be said that prisoners on PMMT altered their social interaction between themselves and staff as radically as some chose to do between their peers, PMMT did have a positive impact on prisoner / staff relationships. The fact that PMMT removed the dual pressures on drug dependent prisoners to pursue illicit drugs and avoid prolonged interactions with staff that might jeopardise this pursuit, meant that relationships could be conducted in a more relaxed fashion. Improvements in prisoner staff relations manifested themselves in different forms.

“Like before [I was on PMMT] I was really hostile . . . Just didnae talk to them at all . . . just ignored them . . . even when they are trying to be nice to you, just used to still ignore them. But now [on PMMT] . . . I do acknowledge them.”

(M001 – on methadone)

“Noo I’m stable . . . I can communicate and actually talk tae them and see who the guy is . . . some guys go “he’s a screw.” The guys only doing his job, the way I see it, if it was me that had a job I’d like tae dae ma job. But that’s the way I see them noo, you know try tae help us.”

(M002 – on methadone)

Long term/life changing motivations

Some prisoners expressed their wish to use methadone as an integral part of their attempts to transform their lives away from habitual drug use in the longer term. This third group of expectations is different from the short-term aspirations described above because they display thinking that goes beyond concern with the here and now. These motivations included prisoners stating that they wanted PMMT in order stay drug free upon and after their release; the belief that methadone could help some to never to return to prison; the desire to make lasting repairs and improvements to family relations and, finally, the realisation for some that it was easier to get PMMT than CMMT.

A significant minority of the study group entered their current spell in prison stable on a community methadone maintenance prescription. By continuing methadone maintenance in prison these individuals felt that they at least had the opportunity to consolidate, or at least not reverse, the gains made whilst in the community. This fact alone was acknowledged to be a great improvement to the situation in prison prior to the introduction of PMMT. One prisoner described the familiar pattern of set-back commonly experienced by those entering prison on CMMT prior to the introduction of PMMT.

“They could be oan that [methadone] fir a year, come into the jail 'n' get taken aff it 'n' then they get back oot 'n' start using again... So having it in jail it helps you a lot when you get oot. Eh, if I wasnae on methadone I’d get oot 'n' I’d

use, . . . I'd have nae intention of moving away or going tae college or doing whatever."

(F011 – on methadone)

The difference in expectations for those entering prison on CMMT since the introduction of PMMT is illustrated by the following example. Despite viewing methadone as “an evil drug” that he wanted to be off as soon as he can manage, this prisoner was extremely relieved to discover in police holding cells prior to sentencing that methadone was being prescribed in prison. It meant that his sentence became an opportunity to slowly reduce himself off his daily dosage rather than return to drug use that he admitted would have resulted from him being removed from his CMMT prescription. When interviewed he was trying to persuade the medical team of his suitability for reduction of his dose so that he could be completely drug free upon his release.

"I've not been in trouble for six years. Ma life's totally different noo. I've got a daughter, and I didnae want to go back the way. I'm plannin' on startin' my ain paintin' and decoratin' business when I get oot . . . That's how it's important fur me tae get aff the methadone . . . Methadone's the devil in disguise, know what I mean. It's a good thing tae get ye aff . . . the drugs but as soon as yir aff the drugs then I think ye should get aff the methadone as soon as you can."

(M016 – on methadone)

This response illustrates well the kind of mixed emotions generated by PMMT in some for whom, on paper, it has been relatively successful. Methadone can keep drug users away from drugs in the community and in prison but at the same time they do not like methadone and want to be free of it as soon as possible.

Stay drug-free after release

An instant return to drug use once liberated was a well-trodden path for prisoners. There was a widespread acceptance that “going out” presented considerably greater challenges to drug users’ willpower than prison did. Consequently, a significant proportion of respondents felt that methadone put them into a better position to avoid drugs upon release from prison. Some prisoners explained that they felt strong

enough to avoid drugs inside yet still wanted PMMT because of anxiety about their ability to remain drug free once released.

“I would like to get back on a script because I don’t know what I am going to do when I get out, I am full of anxiety about getting out, know? Because I have not got a crutch. I have been in and out the jail since I was 16 years old and I know who I am and the way I act when I get out there. I know that if I get out there the noo I have not got the strength on my own back to make things work for myself. I think I have in here but as soon as I hit that gate it is totally different. It is the pressure of being out there and not having anything to do, just it is the only thing I know basically. I go out there and I get mad with it. But when I am on meth, I am not interested in smack . . . because of the routine in the jail, I don’t feel the urge to use the way I do outside. So, it’s when I get out I need it.”
(M015 – wanting methadone)

One prisoner explained that her parents were confused as to why she wanted to be on PMMT when she was drug free in prison.

“[But] the big test is oot there . . . it’s me that’s oot there, it’s me that was the drug addict, ‘n’ I think eh methadone will help me stay aff drugs.”
(F010 – on methadone)

Others expressed the belief that methadone provided them with the security of knowing that if they dabbled with heroin again they were less likely to overdose upon release.

“To be honest with you, when you walk oot ‘n’ you know yer on yer meth you know yer all right if you have a wee dabble. It will be a wee dabble, cos yer no’ gonnae get a habit again ‘n’ yer meth really hauds you.”
(F020 – forcibly removed from methadone)

What was not certain, however, was how many prisoners were on PMMT simply to tide them over until their release. One older male prisoner felt that there was a distinct difference between younger and older prisoners in their respective attitudes towards PMMT.

“There is a lot of guys on this methadone that aren't even interested in coming off drugs . . . most of them are younger guys, they are 21, 22 and they are thinking this will keep me going until I get outside. Naebody will come and visit them. Their mum and dad are not prepared to bring them drugs so they have got no other option, so they think to themselves, “right, instead of being ill with the pain of being off drugs,” and when they get out they will just start taking drugs again, simple as that and they will not stop doing drugs. But for me and for a lot of other guys as well, half the guys on methadone are thinking they have lost too much over the years, there is too many things.”

(M001 – on methadone)

Family

The positive impact that PMMT could have on family relationships in the short-term was discussed earlier in the chapter.

A small minority of the study group talked about methadone in the context of their long-term aims of restoring and improving damaged family relations. Children often brought on such feelings, including guilt about inadequate parenting and the wish to improve the situation.

“I jist want to be off it for my son, growing up.”

(M022 – on methadone)

“I jist want to be normal 'n' be a mum.”

(F017 – on methadone).

What these sentiments confirmed was that some drug using prisoners want to at least try to use methadone as a springboard to not only make improvements with families but to build lasting relationships with them.

Easier to get in prison

For a minority of prisoners, prison was seen as an environment in which to obtain a methadone maintenance prescription more quickly compared to in the community.

“Local people are going into to prison and getting put on methadone and coming out and getting their scripts maintained, where as they can't get on it outside.”

(M023 – non drug user)

Some respondents spoke about their frustration at waiting times before they could access treatment in the community.

“I could get help maybe 6 month doon the line but that’s nae good.”

(M012 – on methadone)

Methadone as a ‘top-up’ measure

Many respondents reported that a significant proportion of those on methadone were not serious about moving away from drugs and viewed PMMT as an insurance measure against withdrawal pains when there was no heroin available. This practice, often referred to as “topping up,” provoked strong feelings amongst respondents.

The value of PMMT to those who chose to continue using heroin as well as methadone was succinctly summarised by this prisoner who recalled his internal monologue during the moment he was first offered the opportunity of going on PMMT:

“When he offered me methadone I could have kissed him, because what I am thinking to myself is, I am not going to rattle again. I am not going to rattle and that was me quite satisfied, and I was gonnae be stabilised plus I would get my charge. Being totally honest, the days I didnae have heroin I could fall back on methadone. Insurance policy, . . . That is all it was for me. . . . I had nae intentions, no good intentions . . . in any part of my body in coming off the heroin. Nae intentions whatsoever”.

(M010 – not wanting methadone)

His story was not unusual. One female prisoner stated:

“It’s [PMMT] the exact same in the outside as it is in the inside . . . something to fall back on if you have no’ got it (heroin) . . . it’s unbearable to get up if you have not got. [With] the meth at least your up and . . . it gives you time to get ready and washed and that, you’re not walking about like a tramp, clatty, going to score.”

(F019 – on methadone)

Another respondent described the benefits of “topping up” compared with using only illicit drugs within his clique.

“There’s four of us, three of us are on the meth but [one] . . . isnae . . . say we’d been burnin’ kit all week . . . wance we’ve nae kit me [the three on PMMT] are brand new but [the fourth not on PMMT] is strung oot but we’re not, we’re just a wee bit rough waiting fae our meth tae come, we go and get our meth and bang we’re up at the gym in the afternoon working oot, he (the fourth not on PMMT) cannae . . . cause he’s lying in his bed going like that (moaning) waiting fae somebody tae go tae a visit tae get a bit of kit, that’s the way it is . . . we’ve got mair leeway.”

(M008 – on methadone)

Prisoners who continued down the twin track of continuing illicit drug use whilst being maintained on PMMT stirred a variety of responses from their peers who were on PMMT and not using illicit drugs or were waiting to start. These responses ranged from unease at what many thought to be playing a high-risk strategy (if they tested positive for illicit drugs they could be removed from PMMT) to contempt towards them. Attitudes towards the issue of using illicit drugs on top of methadone were not black and white however. When respondents talked about topping up, subtle differences emerged as to what was acceptable and unacceptable practice. The practice of using cannabis whilst on PMMT was not viewed as topping up by most drug dependent prisoners and indeed for many prisoners on PMMT was seen as an accepted norm that would effectively be ignored by prison drug testers.

However, the habit of regularly supplementing a daily methadone prescription with heroin long after the start of a methadone maintenance prescription was widely condemned as unnecessary and avaricious by many.

“People are jist being greedy that want the methadone as well and the heroin . . . getting the methadone every day, it’s a guaranteed charge to them, ‘n’ then they’ve got the bonus o’ the heroin when it comes in.”

(F005 – on methadone)

Some believed the practice to be pointless because the effect of heroin on an individual already on PMMT was felt to be greatly reduced, if not negligible.

“You can smoke 3 bags and get nothing off it so it's not worth the risk.”

(M014 – wanting methadone)

The risk that he referred to was that of being removed from PMMT in the event of testing positive for illicit drugs. This risk was felt to be the greatest deterrent for the majority of prisoners on PMMT who mainly avoided taking illicit drugs.

It was not uncommon for these prisoners who condemned, in general, the practice of “topping up” to report occasional use of illicit drugs themselves for one reason or the other. However such occasional use was seen as acceptable as a step to moving towards a different mode of their addiction. Some prisoners, for example, talked about occasional use which occurred during the initial period of adjustment after starting on PMMT as more acceptable.

“I think that you are more likely to top up when you first start your methadone and . . . your habit . . . is still here [points to her brain] . . . When it is still there mentally . . . physically you don't really need it but mentally you do and because it is a habit you are used to doing this routine with smoking and injecting. Eventually you find yourself stable.”

(F012 – on methadone)

This commonly held view relied on the understanding that there needed to be a period of time for a drug dependent prisoner to move from habitual drug use toward stability on methadone. Another view expressed was that until prisoners received the right dosage those new to PMMT might understandably be tempted to dabble with heroin. Those that put forward this viewpoint felt that if the dosage was high enough it would eliminate the need to top up.

“I will say to you 90% of the people who are on a good dose of methadone 50, 60 ml will not touch heroin, definite, they are too feared of getting struck off their methadone.”

(M025 – wanting methadone)

The “greed” of prisoners who persistently used heroin as well as their daily methadone prescription was especially jarring to many prisoners because of the perception that many drug-using prisoners who genuinely wanted to address their drug problem by going on PMMT were being denied the opportunity because their “space” on the PMMT programme was being occupied by someone who was misusing the system.

“There are some people out there that’ll say “oh am gonnae stick to ma script” and then . . . they’re no’ sticking to their script, they’re going out 'n' getting heroin on tap of their script and I jist dinnae agree with that cos there are other people out there waiting to get started on a script . . . That don’t want to take heroin, that want tae get off it 'n' they people are just taking up the spaces fir it.”

(F018 – on methadone)

“They’re messin’ it up for us and other girls that are wanting on it....because the doctor’s looking at it like this “I put you on this . . . and you’re just abusing it, your taking the piss, so why should I gie the next person a chance.”

(F006 – wanting methadone)

Some prisoners reported that methadone was seen as a form of currency by some prisoners. “Leakages” of methadone out of the prison health care system into the prison black market provided some with an additional source of income to buy illicit drugs.

“Methadone is the same as money in prison, . . . they keep the sponge up here [ref: on top of the roof of the mouth] and so the sponge soaks the methadone up so it will have 15, 20 ml soaked up...25 ml is £5 outside but in here, 25 ml you would normally get £10 for that.”

(M025 – wanting methadone)

“You always get the chancers, [they] just get the methadone to sell it for heroin. You will always get the 10% that will do that. They are on a methadone script and they just want to keep it back and swap it for heroin, just take the chance to get kicked off.”

(M025 - wanting methadone)

A non drug user corroborated this when he recalled the practices of a former drug using cellmate who was on PMMT at the time.

“It’s currency, they sell it, imagine putting in their mouths and selling it to somebody else, that’s what they do. See the wee milk cartons ye get in here, they are I think it’s 150ml, two mornings’ methadone will fill wan of these cartons they will sell it . . . they will pass that on to somebody for 10 or 15 quids worth of stuff it’s jist to me, it’s madness.”

(M021 – non-drug user)

Indecision

There were some prisoners who remained undecided about whether or not PMMT was the best option for them. This indecision was most often the product of conflicting counsel from supporters and detractors of PMMT as well as ignorance about methadone and its effects.

Within any one prison establishment, prisoners’ experience of, and advice about, PMMT were abundant. To those considering methadone maintenance for the very first time there was a bewildering array of prisoner testimony regarding how methadone affected them. There were certain fundamentals about methadone that all prisoners agreed upon, such as the belief that it was a more powerful and addictive drug than heroin. Another problem faced by those contemplating PMMT was that methadone could affect individuals differently. This knowledge was gleaned from the opinions and experiences of other prisoners. Their conflicting opinions made building up a coherent picture of pros and cons problematic.

There were, for example, opposing views about methadone’s side effects. Side effects were mentioned in two contexts. The first and most frequently mentioned was the catalogue of withdrawal symptoms. These included hallucinations, aggressive mood swings, sleep deprivation, hot and cold sweats and suicidal thoughts. This intimidating list of mental and physical consequences for those removed from PMMT certainly discouraged many. The second group of side effects were those experienced whilst being maintained on methadone (although very few participants stated that they

had experienced notable side-effects from methadone). These included both negative side effects such as sweating, loss of appetite, inability to sleep, and constipation and positive side effects such as more consistent moods; improved sleeping pattern and increased energy levels. The example of methadone's effect on sleeping was particularly illustrative of the difficulty faced by those seeking advice from their peers about PMMT; some claimed it helped them sleep regularly; others that it disrupted their sleep.

Such conflicting evidence often stirred up uncertainty in the minds of some considering going on PMMT. Making a decision about wanting (or not wanting) PMMT was often the culmination of a long and drawn out, difficult process. One prisoner stated:

“I have an argument for both sides for myself you know? I am glad I am off it because I am eating noo a lot better and I am starting to get a bit fitter and that, I am starting at the gym. When I am on the meth my eating ain't really that good so I am glad that I am off the meth for my health's sake. But at the same time . . . for me being stable it is a bad thing because I don't want . . . I am stuck in the middle . . . Because I am not using or that the noo but when I get out for some reason, I think it is because of the routine in the jail, I don't feel the urge to use the way I do outside. So when I get out, it's when I get out I need it.”

(M015 – wanting methadone)

In addition to indecision arising from conflicting options about the physical and mental effects of methadone, some prisoners were also concerned about the effect on prison life if they identified themselves as active drug users. This is discussed more fully elsewhere but the case study below gives an indication of this problem.

With 18 months left on his sentence one prisoner had a drug problem that he wanted help with. Having hidden his drug use from his partner and, he thought, from prison staff he was attempting to weigh up the pros and cons of PMMT in relative isolation. On the one hand, he had longstanding misgivings about the drug but also felt that methadone, a drug he had never taken, was the only available alternative to drug use for him in prison. On the other hand he was reluctant to continue with the workup towards PMMT because it required him to identify himself as a drug user. Doing this,

he felt, would result in him being “punished;” he would be removed from his work shed, lose his weekly wage as well as his place in the “drug free” residential flat. To add to this concern, many of his fellow prisoners had counselled against PMMT, citing the severity of withdrawals as a major disincentive. The combination of these factors made his decision, like that of many drug dependent prisoners, a difficult one.

Differences between male and female and short and long term prisoners

Male and female prisoners

The majority of male and female drug dependent respondents welcomed PMMT as a major improvement to drug treatment provision in prison. Prisoners of both genders’ attitude towards PMMT was characterised by an acknowledgement of both the potential advantages and the problems that being on PMMT could bring. An individual’s opinion of the possible benefits and disadvantages of PMMT was more likely to be influenced by their own or their peers’ experiences, either current or historical, and circumstances of that individual at that time rather than their gender.

However, some differences were found in the responses of male and female prisoners regarding PMMT and these can be divided into three main areas: the nature of and reasons for their drug use in prison, expectations of PMMT and reasons why they did not want methadone maintenance in prison.

Different nature of and reasons for using drugs in prison

Both male and female prisoners agreed about the negative consequences of in-prison drug use and welcomed the fact that methadone maintenance could, to some extent, provide a route away from these. When male and female prisoners discussed their in-prison drug use two slightly different pictures emerged. The majority of prisoners of either gender, when discussing why they took drugs in prison, cited the fact that they were long-term habitual drug users. Beyond this explanation male and female interviewees emphasised different motivating factors for continuing to use drugs in prison. A proportion of male prisoners emphasised that they took heroin for hedonistic reasons whilst incarcerated. Men were more likely to mention valuing heroin’s ability to help alleviate what they viewed as the boredom of prison life and fulfil a desire for escapism. Male prisoners were also more likely to report starting to

use drugs whilst they were in prison as a coping strategy, their way of deferring the process of coming to terms with a long sentence.

“[Having a] heroin habit . . . was my way of coping with, coping with my sentence, taking drugs to block everything out.”

(M036 – wanting methadone)

A small minority even reported that they missed the challenges presented by the regular pursuit of illicit drugs in prison once they were on PMMT.

“Now I find time in here boring whereas when I was on heroin it was a chase, you were chasing the buzz, that way of life (was) . . . occupying your mind.”

(M030 – on methadone)

The few female prisoners that discussed reasons for their prison drug use were more likely to talk about how heroin helped them self medicate and cope with life in general, as opposed to prison life, and were less likely to praise heroin’s hedonistic qualities .

“Everybody’s got somethin’ different that’s happened in their life, and it’s their way of coping with it . . . (taking drugs) was my way of blocking things out.”

(F024 - not wanting methadone).

There was agreement from both sexes that being removed from CMMT upon admission to the prison system would typically lead to the pursuit of drugs in order to ease withdrawal pains from methadone. Of the female prisoners who specifically talked about the reasons why they took drugs in prison, most cited being “struck off” their CMMT as the predominant factor.

Among those who continued to use illicit drugs in prison, both women and men discussed a similar set of tactics to ensure that they used these drugs as regularly as they could whilst they were in prison. There were common themes: making constant enquiries about which drug using prisoners were expecting visits; bartering for drugs with money, tobacco, phone cards, IOU’s and methadone; “camps”; bullying and intimidation and the violence that was often caused when expected parcels of illicit drugs did not materialise. Respondents, irrespective of gender, described the social

interactions of those intent on taking drugs as being typified by an uneasy combination of the individual's selfish instinctive desire to maximise their drug intake whilst simultaneously having to be reliant on a network of likeminded individuals for regular supply of drugs. They also shared concerns about how their drug use was affecting their family relationships. Despite these similarities, there were differences in what women and men said about the strategies they employed.

Male prisoners tended to talk more and in more detail about what was required to sustain regular drug use in prison. Male prisoners discussed the role their family played in helping to fund and/or supply their prison drug habit much more often than their female counterparts. Drug dependent male prisoners tended to be frank in their admission that their conversations with family and friends often involved a variety of tactics designed to persuade them into collaborating in the task of supplying illicit drugs into prison. They described requests, blackmailing strategies and demands for money and co-operation from their family or friends. The phenomenon of the "send-on" was mentioned almost exclusively in the responses of male prisoners.

"I have got a big family and I was phoning different members of my family, getting £10 off one of my brothers, £20 off another brother, £30 off my sister, my mother. Get it sent to an address and as soon as the money arrives you get your heroin."

(M031 – on methadone).

In terms of social interactions between prisoners who were regularly using drugs in prison, male prisoners described a more severe brand of violence, resulting from grievances caused by drug dealings in prison, than their female counterparts.

By contrast, women were much less willing than their male counterparts to specify the details about their prison drug use and how they sustained it. Those who did elaborate on these topics seemed to outline a much smaller scale of illicit drug use in terms of the amounts of funding, drugs and outside help involved in their "regular" drug use than their male counterparts. Whilst men often talked about asking family members for specific sums of money, females, typically, talked about being reliant on personal prisoner cash, bartering tobacco and phone cards, or even their savings in the

community as sources of funds to pay for prison drug use. Describing the pattern of drug use in the prison, one prisoner observed that:

“There is . . . no one main drug dealer it's not like that it's just that everybody . . . gets it in . . . it's nothing big.”

(F019 – on methadone)

Mention of phone calls to family requesting finance and/or supply illicit drugs into prison were rare, as were reports of actually receiving family support in terms of getting parcels of drugs in at visits. However, this is not to say that women did not do these things, simply that they were far less comfortable discussing details.

Different expectations of PMMT

Responses of male and females interviewees about their expectations of PMMT differed somewhat in two main areas. The first area concerned expectations about what PMMT would help the prisoner achieve.

The second area was the differing attitudes towards those prisoners on methadone maintenance who continued to use illicit drugs.

When asked if they expected to be on PMMT at the time of their release from prison, most respondents of either gender who were on PMMT or wanted to be on it were either unsure or expected to leave prison on a methadone maintenance prescription. A minority of female prisoners, however, were aiming to use PMMT with the intention of being drug free before their release. The bulk of male prisoners on PMMT or waiting to get on it were simply unsure about what position they would be in vis á vis PMMT at their release or believed that they would leave prison still on methadone maintenance. Only four male prisoners specifically mentioned their wish to reduce themselves off PMMT so as to be drug free during their sentence. One prisoner represented the majority view of male interviewees on this issue.

“With the meth if you use it to your advantage then you have got a walking stick to go out with.”

(M037 – on methadone)

A significant minority of female prisoners talked about their ambition to utilise the length of time remaining in their sentence in conjunction with PMMT as a form of drug rehabilitation, that is, they aimed to use a methadone programme initially to stabilise their drug use with a view to becoming drug free before liberation.

“[I want to] get something out of this sentence and at least come out of this drugs free.”

(F019 – on methadone)

“See if you are in the jail long enough you want to get off the meth and all. Like give yourself the opportunity to get off the meth and then go out and be just straight, that is easier said than done it really is . . . but I would rather be clean and leave the jail. I wouldnae want to take meth outside again.”

(F013 – wanting methadone)

Attitudes towards using illicit drugs whilst on PMMT differed between men and women. Female respondents expressed less tolerant views of this practice than their male counterparts. Whilst prisoners of both genders expressed a sense of frustration about this practice, a larger proportion of female respondents were more vocal about what they perceived at the injustice of someone “not serious” about PMMT occupying one of a limited number of PMMT spaces. One female prisoner expressed the exasperation felt by many of her peers.

“Some of the other lassies in that hall I’ve walked by when they’ve been sitting with the drug worker and they’re sitting in tears. They’re really wanting to get on their methadone, and get off the drugs . . . and they cannae get a script because . . . maybe there’s only limited places, or maybe somebody else is usin’ a place that they shouldnae be usin’ because they’re not ready to come off the heroin. They’re just using the meth as like a . . . free buzz . . .”

(F003 – on methadone)

Female prisoners, however, felt that this practice was less prevalent amongst their peers compared to reports from male interviewees. Most females believed that ‘topping-up’ was a minority activity whereas male interviewees thought that the majority of males on PMMT also used illicit drugs.

Long term and short term prisoners

When the responses given by the study group were analysed according to length of prisoners' sentence, there was little difference between what short-term convicted and long-term convicted prisoners said about PMMT. One area of divergence did emerge however, and it surrounded the issue of supply of illicit drugs; specifically, how the issue of supply was affected by length of sentence and different prison establishments. There was a crude correlation made by most prisoners that if a prison had a) a dynamic, fluid prisoner population that included both tried and untried inmates and b) the obligation to provide frequent visitor rights to this population then there would be greater opportunities for a drug dependent prisoner to source illicit drugs in prison.

Additionally, being in a local prison establishment meant that the prisoners could call on a supportive network of family and friends who were more likely to live closer to the prison to collaborate in the business of arranging imports of illicit drugs via visits.

High security prisons were a more challenging environment in which to sustain a regular supply of drugs than a local prison. On top of having a greater amount of time to serve, long-term convicted prisoners were often entitled to a reduced number of visits and were more likely to be further removed geographically from supportive networks of family and friends who helped facilitate the supply of drugs. Regular pursuit of illicit drugs during a long sentence usually meant greater financial cost, a greater price paid in terms of damage to family relations, increased exposure to the risks of contracting blood-borne viruses and a greater likelihood that they would be penalised for drug offences. Those without significant resources to call on in the community acknowledged that the combined effect of these factors greatly impacted on their ability to sustain a regular supply of illicit drugs. Some long-term convicted prisoners chose to settle for the frustrations of a sporadic supply of illicit drugs, others factored the conditions they faced into their individual deliberations about whether or not they should try PMMT. One such prisoner talked about the how combination of his long-term convicted status and his transfer to a high security prison influenced his increasing weariness with the pursuit of illicit drugs that subsequently led to his request for PMMT:

*“I was getting visits and getting a wee bit in cause its ma local jail next tae [his home town]. Since I came up here . . . I’m struggling tae get parcels up cause this jail is famous fae getting lifted. . . . About 4 or 5, 5 months after I came up here I had a habit, so was I just basically p*****d aff with it chasing, just that’s all you dae in the morning fae 8 o’clock.”*

(M038 – wanting methadone)

The time an individual prisoner had served of their sentence was also raised by some prisoners as having a role to play in long-term convicted prisoners’ attitudes towards PMMT.

“[When prisoners have] jist started their sentence cos they’ve jist got the sentence they’re...don’t care about anything... the way they think about it is jist take heroin 'n' they’ll get through their sentence faster . . . I thought like that. At the start of my sentence I did but once I came up here 'n' I started taking it at first I thought it wis great . . .once I got into about 7 month of ma sentence . . . I knew I hid tae try 'n' get aff it cos it's basically...the way I can see daeing a sentence is hopefully . . . learn something fae it, hopefully I get something oot it for myself...that’s the only way I can see a sentence 'n' that’s the way I’m seeing it the noo so if I can get something oot it 'n' get aff heroin 'n' oan this methadone.”

(M039 – on methadone)

This prisoner’s story of marking the start of his long sentence with a period in which he was active in the pursuit of drugs that was followed by a period of reflection about his in-prison drug use was fairly typical of the testimony of male long-term convicted prisoners. By contrast one short-term convicted prisoner commented that the combination of a short sentence and what was perceived as a complicated workup to PMMT conspired to discourage prisoners with less than a year to serve from considering PMMT.

“The way people look at it [is] if you are no daeing at least 12 month there is nae use you even trying . . . it's [PMMT] awful hard to get on it in here it's basically a waste of time.”

(M040 – forcibly removed from methadone)

CHAPTER 4. WHY PRISONERS DON’T WANT PMMT

The reasons for not wanting PMMT were, in the main, more clear-cut than the often complex combination of reasons for wanting the treatment. The group of prisoners expressing negative views about PMMT consisted of those who had had negative personal experiences of methadone in the past as well as those without this experience. Six distinct reasons emerged from the interviews: bad experiences of methadone withdrawal, preference for the lifestyle involved in the pursuit of illegal drugs in prison and the preference for the ‘escapist’ properties of using heroin, problems with the workup process, issue of control, ignorance and stigma and, finally, the use of alternative solutions to cease drug use. Differences between male and female and short and long term prisoners are described at the end of the chapter.

Experience of methadone withdrawals

There was widespread, almost universal, belief among all drug using respondents that methadone was a far more powerful drug than heroin. Many drew upon their own or others’ experience of methadone withdrawal as evidence of this. Withdrawals from methadone were commonly judged to be far more severe than the equivalent withdrawal experience from heroin. Such was the fear of these withdrawals, that this fact alone often was the single greatest disincentive towards choosing PMMT for drug using prisoners. There was also agreement that experiencing this in prison magnified the ill effects of methadone withdrawal because the environment itself, with its erratic drug supply, made self-medicating to ease the pains of withdrawal problematic. For some, the experience was so severe that it convinced them against methadone as an option for them forever. For others, just seeing and hearing from those who had gone through the experience was enough of a discouragement. Even non-drug users testified to the horrific side effects they witnessed on drug using cellmates withdrawing from methadone. One prisoner succinctly captured the widely reported plethora of physical and psychological after effects experienced during methadone withdrawal.

“No sleep, coldness, jist no bein’ able tae get yer food doon, lookin’ odd, feelin’ odd, ye know jist no right all the time. Withdrawin’ into yersel . . . if ye come aff a drug like that, yer mind’s gonnae go cuckoo, ain’t it?”

(M019 – forcibly removed from methadone)

These symptoms were largely acknowledged to last for a lot longer than the equivalent withdrawal period from heroin.

“With heroin, you’re maybe uncomfortable for three, four days, then you start feeling back to yourself. With methadone, it can take weeks, maybe thirteen, fourteen weeks before you start actually feeling kind of back to yourself again.”

(F008 – not wanting methadone)

One prisoner explained that the severity of the effects he experienced when he was “struck off” a 5ml daily CMMT script in prison in 2001 and the subsequent 10-12 weeks withdrawal period constituted the “*worst experience of his life*”. Prison life at that time, he continued, was characterised by suicides directly attributable, in his mind, to prisoners who had their CMMT discontinued. He counted one of his friends amongst those who took their own lives during this period – he was one of twelve suicides that occurred in the five months prior to his release in 2002. The respondent remembered this period as the time during which there was a thawing of what he saw as active SPS opposition to methadone maintenance programmes and the adoption of a pro-active stance towards PMMT. Although his words represented a minority view amongst the study group there was no doubting the profound effect this period had had on him (and others) and his attitude towards PMMT.

“I would not want to experience what I went through again, that is what I said to myself that I would never, never touch it again and I have stuck to my word. I would rather have a habit if it came to it.”

(M017 – not wanting methadone)

Those who maintained a determined stance against PMMT were rare, however. Much more common were those who characterised their attitudes towards wanting and not wanting PMMT as flexible and many more reported having revised previously held entrenched positions. One female respondent was probably more representative of the great majority of drug using prisoners when she stated:

“Well when I came off it the first time I swore I would never go on it again but circumstances got that bad for me I had to go back on it and really I was that down and that low I had to go on it, and here I am trying to get off it again.”

(F019 – on methadone)

Most prisoners who preferred to pursue illicit drugs rather than go on PMMT felt that they could cope better with withdrawal from heroin than withdrawal from methadone. Many with experience of both talked about preferring the “2-3 day rattle” (withdrawal period) typically endured when there was no heroin in prison than the potential “6-8 week rattle” commonly associated with being put off a prison methadone script.

Drawing on her extensive experience of methadone maintenance in the community and in prison, this prisoner compared the relative merits of methadone maintenance and using heroin:

“Methadone is all right...[in the] short term...but in the long run...I would be worse off whereas [with] me just hanging a habit the now, for three or four days of being uncomfortable is much better than 13 weeks of not sleeping, being exhausted in your mind, just completely gone, if you do get took off it.”

(F008 – not wanting methadone)

Preferred illicit drug use

The second most prominent reason for not wanting PMMT was that some individuals preferred to pursue illicit drugs in prison. Preferring “a habit over a script” encompassed a number of distinct reasons. Firstly, heroin’s escapist qualities made it a proven commodity for prisoners seeking to alleviate the boredom of daily prison life and the stress of what they had left behind in the community.

One prisoner explained the appeal of heroin to him was that it was something that removed his thoughts from the context of the heavily regulated daily routine of prison.

“It is groundhog day in here, every day of the week is the same, up at the same time, fed at the same time every morning and then all day, put to bed the same time at night. It is a boring, boring routine. Heroin or drugs, sleepers or whatever takes that away.”

He recalled how his thought processes at the start of his long sentence led to his first introduction to heroin.

“25 year to life. . . . at my age. I felt sorry for myself . . . it was playing on my head all the time. All the time I was looking for an escape route and I listened to a lot of people “aw heroin is great, it takes you away, when you are on it you are not in prison” and it was the truth, it was the truth. There was no lies there, it took your head right off. You are not in the jail, you are on a beach in the Caribbean.”

(M010 – not wanting methadone)

Many prisoners echoed these sentiments.

“It’s an easier way tae handle jail life, its as simple as that”.

(M007 – wanting methadone)

Not just escapism, with little to occupy themselves with in prison, some prisoners enjoyed that fact that a day went quickly past as they were absorbed in the chase for heroin.

Another factor was, that due to adequate finances, some prisoners could achieve a steady flow of drugs when they wanted them and so the reason to want PMMT to stop withdrawing in prison was obviated. A prisoner in such a position explained that because of the profits accrued from drug dealing prior to his sentence he was better able to supply and fund his prison drug use:

“For me personally, I could get my missus to send money . . . it’s not a problem when I want anything. It’s there when I want it. It’s just I mean fae dealing . . . when I was oot there I managed to put a good bit of money to last, for me personally it’s no a problem, but for other guys it could be”

(M024 – not wanting methadone)

Another advantage of having greater resources, according to these individuals, was that this could generate alternative opportunities such as paying other prisoners to receive incoming parcels of drugs if their own visits came under surveillance. These individuals represented a privileged minority within the drug using prisoner population and the majority of drug dependent prisoners could not afford such luxury.

“Workup” towards PMMT

For a few respondents the processes involved in the “workup” proved to be a disincentive from going on PMMT. Their chief complaint was that, as part of this process, prisoners had to identify themselves officially as having a drug problem and that, they believed, brought with it a potential range of punishments. Punishment might take the form of stalling their progression through the SPS system or, perhaps, unwanted attention to themselves, family, friends and associates during visits. As one prisoner put it, a lot of drug using prisoners, were, like him, reluctant to present themselves for PMMT because they had a fear that doing so would “mark their card.”

Another prisoner agreed, adding that the expected long waiting times and the need to provide positive drug test results during the workup phase discouraged many considering PPMT as an option.

“You wait fae six month tae go on the meth, [it is] mair trouble than its worth . . . [and] you need tae provide positives and all that at first, when you start providing positives you just bring a lotta hassle upon your self . . . they’re gonna start jumpin on tap of your visitors.”

(M009 – on methadone)

Across the study group there was a variety of complaints about the processes involved in the running of PMMT. Most of these resulted from a lack of clarity and communication between prisoners and staff about how PMMT actually worked. The problems with process, including workup, are discussed in a separate section.

Control

The issue of control made up the fourth most common group of reasons for not wanting PMMT. Control was mentioned in two ways. First, a minority were strongly opposed to what they saw as the prison authorities having leverage over them in the form of PMMT. For them PMMT, could not be separated from the prison system’s mechanisms of control over the prison population.

“[It’s] a form a control fae them know . . . you’re on the methadone you need tae jump through hoops.”

(M009 – on methadone)

The fact that the prison service controlled a prisoner's medication as well as their movement and liberty jarred with some, usually older prisoners, who remained staunch supporters of a "them and us" approach to prison life.

Central to this outlook was the belief that once a prisoner was on a methadone maintenance prescription in prison, the authorities had unacceptable, potential leverage over his daily activities because they controlled the drug that alleviated his daily withdrawal pains. Some prisoners also subscribed to the view that those on PMMT were a source of prison intelligence about incoming imports of drug. Such information, it was believed, was exchanged for leniency in positive drug test cases.

"You get the security screw and he'll say "dae you want a drugs test" and that's a way fae them tae get you oot the way fae everybody else so they can interview you and find oot what's happenin' in all the other halls . . . people on methadone script, they're all grassing each other . . . I know guys in here that's on methadone and will come back and tell you these things know, "the security pulled us up there and asked us what's happenin' in the hall and that and you can be ma special pal." I'm just not havin' any of that . . . I've got ma ain rules in the jail and I don't associate with the screws, take nothing tae dae with them, so if they put me on methadone then they've got me by the balls, know?"

(M005 – not wanting methadone)

"Two people on methadone one is a grass and one is not, the two of them gets caught with opiates in their system, one of them gets taken aff the methadone and the other one doesnae. What does that tell yee? Only tells you wan thing. He is a grass. There are terrified of getting taken aff their methadone, because they know that they will get a bag aff naebody. Terrified of getting taken aff their methadone."

(M010 – not wanting methadone)

Many prisoners distrusted official assurances that PMMT was operated as a separate concern from the disciplinary arm of prison. As evidence of this lack of separation many prisoners provided examples of pressure being put to bear on the visits of prisoners who had started the workup process. Many preferred to trust their instincts

that told them that prison was too close an environment for there to be an effective separation of the therapeutic and punitive.

The second “control” issue was the perception that methadone itself would exert too much control over the individual’s functioning in the long run.

“I feel when I use heroin . . . I feel in control whereas if you are on methadone you’re no in control, it’s controlling you . . .

(M024 – not wanting methadone)

Ignorance and stigma

The fifth main reason why some prisoners did not want PMMT arose from their perceptions of methadone. As we have seen, peer experiences and advice about methadone were a powerful source of information for prisoners. This meant that negative and often ill-informed views contributed to the individual’s decision-making processes about PMMT. Responses from those who wanted and did not want PMMT often showed an incomplete understanding about methadone and its effects. Lack of knowledge and misinformation were blended with personal testimony to produce a potent cocktail of “truths” about methadone that were circulated and perpetuated amongst drug using prisoners. Peer testimony and advice carried more weight amongst drug users than official explanations of PMMT. This created circumstances in which individuals regularly started methadone maintenance in prison with a degree of uncertainty about the drug and its effects.

One of the reasons that many negative opinions circulated amongst prisoners was that many prisoners who positively endorsed PMMT as helping them to improve their quality of life in prison often chose to keep “themselves to themselves”, to withdraw somewhat from mainstream prison life. Some of these prisoners talked about their opinion of being on PMMT as a very personal one, often qualifying their statements on the subject with the phrase, “I can only speak for myself...”

There was little evidence of any widespread stigma attached to those on PMMT, although there was some stigma towards the drug “methadone” itself. Some prisoners interviewed talked derogatively about those on PMMT.

“Weak people, people who cannae dae their time without a charge.”

(M005 – not wanting methadone)

The implication was often that prisoners on PMMT were not serious about coming off drugs and were only on methadone to avoid withdrawals from heroin during periods of lean supply. These opinions were the exception, however, rather than the rule. Indeed, more prisoners talked about jealousy towards those on PMMT rather than a sense of stigma.

“There is a stigma put on it because people are jealous, that is really what I think it is. Some people want to go on it but they dinnae want to go on it because of peer pressure and other people cannae get on it because there are only so many numbers in the jail can go on that methadone, and I think it really boils down to jealousy at the end of the day.”

(M001 – on methadone)

This envy was based on drug using prisoners contrasting the daily stability of those on PMMT with their own roller-coaster existence. Often, when stigma was mentioned, it was in relation to individuals regarded as not being worthy of a PMMT place because their drug use was not judged severe enough.

Other methods of becoming “drug free”

The final reason why prisoners did not want PMMT was that some preferred to use methods other than methadone to move away from a drug taking lifestyle whilst incarcerated. These “methods” included willpower and active involvement in mainstream prison activities such as work sheds and physical exercise, social isolation within the prison and the supportive role of family. One prisoner talked about the combination of willpower, family and keeping “*herself to herself*” as the combination of elements that helped her avoid drugs,

“I’ve never took drugs in the prison . . . cos it’s only ma kids that come up tae see me and I would never ask them to bring anything up tae a prison, so I wouldnae take anything . . . doesnae bother me . . . I jist sit in ma room and keep masel tae masel.”

(F018 – forcibly removed from methadone)

Another respondent talked about how his relative social isolation within jail combined with the fact that only his mother would visit him helped him stay away from drugs.

“I don’t know a lotta people in here, it’s never came my way...it might but the people who have got it, they tend to camp up with each other, so unless you’re getting drugs in yersel’ nobody is gonnae offer you nothing . . . I have only got her [his mother] to come down and see [me] . . . ma mam wouldnae bring me any in...I don’t want anymore...I want to try...this place is bursting ma nut, I wanta just get oot there and get on with it and I’m never coming back here again . . . I just keep ma head down and get on with it, I don’t bother with anybody so nobody bothers with me.”

(M013 – not wanting methadone)

Following intense consultations with her personal officer, her drug dependent partner and drug worker, one prisoner chose to rely on her willpower to move away from habitual drug use. She went through withdrawals with the help of her work.

“What I had to dae was . . . jist threw maseel into ma work constantly 'n' back in the block, lock up, watch telly back oot 'n' dae anything jist tae get shot of that craving 'n' then before a knew it, it was gone”

(F016 – not wanting methadone)

Another young prisoner who stayed drug free in prison but was worried about the possibility of a return to drug use when released, initially considered PMMT to be her only viable option to avoid this before being persuaded against it.

“When I first begun this sentence I said to one of the addiction nurses that I want methadone and he talked me through it and talked about drugs and this and the next thing. I was in a couple of programmes like the SMART programme, drug counselling and all that. I find that I didnae really need methadone because I am not going out to a habit. There is no reason why I should have a habit when I get out.”

(F015 – not wanting methadone)

She credited the SMART course (Self Monitoring and Recovering Training programme) with a shift in her focus: instead of allowing thoughts of craving for

heroin to dominate, she concentrated on wanting to build on the gains she achieved in prison (staying drug free) in the community. Although prisoners who preferred to use these alternatives to PMMT were in a minority their experience showed that PMMT was not the only solution away from drug use available to prisoners.

Differences between male and female and short and long term prisoners

There were no differences between short and long term prisoners and only a few differences in the responses of male and female interviewees about reasons why they might not want PMMT. There was a clear consensus between prisoners of both genders that fear of withdrawal from methadone was the predominant discouraging factor about PMMT.

Among a small sub section of male interviewees, there existed an almost conspiratorial perspective about the introduction and administration of PMMT by prison authorities. This range of views can be summarised by the belief that, to a greater or lesser degree, PMMT could be used as a form of control over drug dependent prisoners by the prison authorities. Those who took this view were all male.

*They have got control over you . . . That is the only reason they brought it in to start with . . . it is a big brother is watching you type of thing . . . it is a smart move they have made because there is people running about mad with it, they are not controllable and screws like to be in control . . . They know that they cannae go “if you don’t do this we are cutting yer meth.” But at the same time they could lead you into a false sense of security... [for instance] if . . . it becomes general knowledge in the hall that it is cool when you are on meth . . . they are not that worried about hash, right? Just to lead you into that false sense of security . . . then you have got a bad day with one of they screws and that screw goes like that “I don’t like that ***tard.” . . . they can turn round [and say to a colleague] . . . “Listen he has just failed an MDT for hash, do the damage.” And that is the way it works. Definitely . . . they have got too many different rules for different people for it not to be working that way and they have got no strict policy written down on paper so they can bend it.”*

(M015 – wanting methadone)

One prisoner in another establishment said of this issue:

“I think it's just a crutch . . . to help both parties . . . It's about the management . . . methadone . . . cuts down on drug deals, cuts down on the smuggling, cuts down on the family burden . . . [but] I think it's the management (SPS) that are benefiting more from it than anybody.”

(M023 – non drug user)

Female interviewees tended not to be as suspicious about the motives of the prison service in relation to PMMT and most believed that PMMT was intended only to help drug dependent prisoners. One female respondent dismissed the notion that PMMT might be used as a control tool for prison staff:

“If you don't want to go on it [PMMT] then you don't need to go on it, I mean they're not forcing it doon yer neck...they are not twisting your arm up your back tae go 'n' get it...we approach them...we have to approach the staff 'n' tell them that you're wanting help to go on a methadone script. It's not as if they're coming up 'n' saying your going on it, ken, if you didnae want to go on it then you didnae have to go on it.”

(F018 – on methadone)

CHAPTER 5. PROCESS OF PMMT

Prisoners were asked to talk about their experiences of the processes that managed the provision of methadone maintenance in prison. The processes described ranged from the period of transition from the community, through police custody, into the prison system and being on PMMT. Drug-dependent prisoners took a keen interest in the processes that governed the management of methadone in prisons. Their feedback tended to concentrate on the consequences of these processes for the individual; perhaps understandably, much prisoner comment in this area described in great detail ‘injustices’ as they saw them. However, in a few instances, the difficulties for the prison service in managing this policy were acknowledged.

Prisoners highlighted two significant underlying factors that they believed underpinned the workings of PMMT. The first was that prisoners were aware that many aspects of methadone treatment in prison remained unwritten, flexible and were subject to frequent changes and interpretation. From experience they knew that different prisons had different methadone policies and that within each establishment that policy was evolving. This flexibility was often the source of grievances and many made the observation that there seemed to be one rule for some and another rule for others. One such individual complained:

“Some nurses or some doctors must play by different rules . . . I think there should be set rules whether you should get something or not . . . not different rules for different fools.”

(M016 – on methadone).

The lack of a precise policy on PMMT caused confusion among prisoners. There was a lack of understanding about why certain decisions were made at all stages of the PMMT process: from the process of starting someone on PMMT to removing them from it. Many were at a loss as to why some prisoners got methadone and others did not, why some were removed for testing positive for illicit drug and others escaped this fate. This confusion often resulted in frustration and disillusionment with the system.

The second factor that underpinned prisoners' perceptions of the processes of PMMT was the widespread belief across all establishments that there was a "cap on numbers" that affected who received PMMT. One prisoner summed up the belief of many respondents by stating:

"It seems to be before anybody gets on methadone somebody has to come off it."
(M003 – forcibly removed from methadone).

Within the context of these two beliefs: no strict, precise policy and the system of "capping", prisoners discussed six key areas of concern with the process involved in PMMT. The first was the management of transition of those on community MMT from police custody into the prison system. The second area was the 'workup' process or "how to get on" PMMT during a sentence. The third was the inherent contradictions that prisoners believed were part of the process, particularly that some of the processes that governed PMMT also punished those who were seeking help. The fourth key area was the consumption and diversion of methadone in prison. The fifth concerned prisoners' thoughts on monitoring of those on methadone in prison. The last was the vexed issue of 'non-voluntary reduction'. Many prisoners complained about the protocols managing the removal of individuals from their methadone prescription in the event of them testing positive for illicit drugs.

Transition

Many respondents were on community MMT prior to their incarceration. For them being imprisoned was stressful not only because of a loss of liberty but also because of a potential loss of their methadone maintenance prescription. Many reported being 'struck off' at admission once they tested positive for illicit drugs as well as methadone (discussed later in this chapter). Reflecting on this, some were resentful and felt let down by the system.

The most commonly heard complaint about this period of transition was the 'problems' caused by medication prescribed by police doctors. Several respondents talked about being given drugs whilst in police custody that later resulted in a positive urine sample upon admission to prison and discontinuation of their methadone script.

“I was on methadone at that time for a couple of years. . . [but] because I had the dihydrocodeine in the police station and because I had dihydrocodeine in ma system . . . they never [gave me] ma methadone.”

(M045 –wanting methadone).

Others pointed to what they perceived as poor communication between the prison and outside agencies. These individuals reported a delay of several days to get the issues surrounding continuing a methadone prescription clarified. One such interviewee claimed:

“I came into prison... on the Monday and I went for a medical check and they asked if I was on any medication I said the methadone script and he said ‘well we cannae give you that right now until we get in contact with your doctor. So I waited another 6 days before ma doctor got in contact with them and [they] geed me ma methadone again.”

(M002 – on methadone).

Such prisoners talked about these delays as extremely stressful and challenging because of the danger that the hold up might lead them to ‘top up’ with another drug to stop them from going into withdrawals. Prisoners’ exasperation at these delays was often compounded once their prescription resumed. Some reported recommencement with a reduced daily dosage that was increased over time. The prison doctor, from a safety perspective in case of overdose, could take a few weeks to bring the dose back to what the prisoner was accustomed to outside, however this caused further discomfort for the prisoner involved. Only one prison had a policy that if someone had been on community MMT for less than 6 months then it was automatically continued in prison. Thus prisoners received their methadone the day following admission; there was no staggering of doses, rather the full amount was given straight away.

‘Workup’

‘Workup’ was the phrase used by some prison addiction teams to describe the period of assessment that preceded a drug dependent prisoner starting on PMMT. Across the different establishments there was a wide variety of assessment practises and ‘work-ups’ prior to a prisoner being put on a methadone script. The variety of responses also

emphasised the fact that ‘workup’ within each establishment was continuing to evolve. What was clear was that, with a few exceptions, the route towards receiving PMMT often baffled prisoners and that this was a source of great frustration for many.

Recounting their own experiences prisoners described both fast and slow track assessments occurring. Some talked about getting on PMMT in a matter of days and weeks, others after months of waiting.

“Fast-track assessments”

Across the study group respondents were certain about three sets of circumstances in which individuals were likely to be “fast tracked” into PMMT. Firstly, they clearly understood that those on community MMT who provided a ‘clean urine’ sample upon entering prison would have that prescription continued. Secondly, female interviewees understood that pregnant drug-dependent prisoners received PMMT as a matter of course. Thirdly, respondents were aware that drug-dependent prisoners deemed ‘high risk’ because of their blood-borne virus status and/or injecting behaviour were also likely (if identified) to be fast-tracked onto PMMT. They knew that those within these priority categories could be put on methadone even if the system was ‘capped’ for others. They accepted that in these circumstances rigorous assessments were not always deemed necessary before methadone was prescribed.

“I got hepatitis C and they made me go on interferon and that, ken? . . . So, I seen the doctor. . . seen the nurse and after about three or four days they decided to put me on methadone . . . I didnae have tae dae drug diaries ‘cos I was only [waiting to get methadone for] . . . a couple of days. They wanted me on methadone maintenance to keep me away fae jagging.”

(M026 – on methadone)

Although prisoners were clear about the principle that lay behind this scenario, they showed little understanding of just how staff came to label some prisoners ‘high risk’. Some prisoners, even though they appeared to fill the blood-borne virus risk criteria, were not always quickly put on MMT.

“It is very difficult to get on methadone in here unless you are on it on the outside when you come in . . . Look at me right? Hepatitis C, jaggig, took 2 OD’s this sentence . . . I am a pure candidate for methadone . . . If they would put me on methadone, 40, 50 ml that would be it. I would stop the needle, stop everything know what I mean? [I’ve] seen Cranston for months and months and doctors and then you have got to attend a case conference team “Why do you need methadone? Why should you be on it?” All that carry on. It is like a job interview. 50 people will apply, out of that maybe 15 people will get it.”

(M025 – wanting methadone)

Slower-track assessment

Most respondents reported that their circumstances did not match these sets of criteria and instead described a longer assessment process. From the perspective of the addiction team, the purpose of this ‘longer assessment’ was to gauge an individual prisoner’s motivation before starting them on PMMT. Although most respondents acknowledged that it was important for the addiction team to do this, many were left frustrated by the workup process. Most agreed with this individual who believed that ‘workup’ could be characterised by the *“need tae jump through hoops”* (M009 – on methadone). There was much confusion amongst prisoners in all establishments and amongst all prisoner groups about the selection process to start methadone in prison. Many prisoners had been trying to get on MMT for a long time but did not understand what was actually required of them to receive MMT or what the hold up was. In the worse case scenarios the system was so opaque that they became disillusioned and gave up hope of ever getting PMMT.

‘Non fast-tracked’ workups tended to follow a similar trajectory in all establishments. Beginning with a request for help for drug dependency issues, the process was followed by referral to the addiction team (addiction officers, nurses and doctor), a period of assessment and then a decision to start or delay commencement of PMMT. One prisoner described her own experience of this process:

“I asked to see a drugs counsellor, cause I wanted . . . to be put back on ma methadone. . . ma PO she arranged it for me. [The drug worker] tried to get me back on ma methadone, cause when I first came in I was all over the place. I think he tried about three times put a referral in, he puts a referral in. He has

a meeting with the doctor.... The doctor was just not having it. He... looked at ma file and seen how much methadone I was on, I wisnae asking' tae get put back on 200 ml, but he just looked at how much I was taking . . . he just mair or less said no way . . . That was that, nae reasons, nothing."

(F007 – forcibly removed from methadone)

This is a good example of how many prisoners talked about the 'workup' process. Most clearly understood the procedure in terms of who they had to speak to and in what order. However, there was little comprehension of how decisions were made during the assessment. As a result, many felt disconnected from the decision making process. Often this was exacerbated by the knowledge that other individuals were 'successful' in the same process because they misled the addiction team by, for example, exaggerating their drug use.

Some respondents singled out two components of the assessment process (in some establishments) as particularly clumsy: diaries and gatekeepers.

Diaries

The use of diaries as a tool for assessment and work up occurred in 4 or the 5 establishments. There was a mixed feeling about the use of diaries. The benefit for staff was mainly gaining insight into how much heroin the prisoner was using; this would help assess whether he had a sufficient level of addiction to start MMT and also to inform about the correct starting dose for methadone. Some key worker staff also wanted to analyse when during the day the prisoner was using drugs. Patterns were looked for in the hope of finding an activity during these times that could take the prisoners out of a high risk position. One drug worker also commented that the diary was useful to look at again after the prisoner had started methadone and they were undertaking a relapse prevention course.

Most staff thought that the diary could benefit both staff and prisoner. Staff stated that the benefits for prisoners were that they helped to clarify to the prisoner the extent of his/her drug use. This was occasionally also stated by prisoners.

*“I was looking at it last night....when I was writing it and I was looking back at last week – what I used. I was looking back, ‘**** sake’, didnae realise it was that amount.”*

(M039 – on methadone)

However, the majority spoken to did not share this view. Prisoners knew that the intention of the diary was that they would honestly reflect the type and amount of illicit drugs they were using to help in the assessment process. Very few of those who discussed completing these diaries reported that they were honest about their drug consumption. Some prisoners were reluctant to do this because they did not trust that the information would remain confidential. They were also concerned that the information would be passed to security resulting in their families being bothered at visits. Most prisoners who mentioned diaries thought that they were only for the benefit of the staff, and were a way of gaining intelligence about drug activity, a stalling technique or just ‘*a hoop that I had tae go through tae get there (PMMT)*’ (M032 – on methadone). One prisoner summarised the opinion of many by stating:

“Drug diaries . . . I can see their point just to see what I have taken but they are coming back in with these daft sheets asking the reason why you want off drugs . . . you ask a stupid question you just get a stupid answer . . . The answers are what they want you to say.”

(M046 –wanting methadone)

Gatekeepers

In one prison, several prisoners commented on a personality clash between themselves and one member of staff who held a key role in ‘deciding’ who received PMMT. One prisoner reported that she felt compelled to abandon her request for help with her drug problem in prison such was the acrimony that she felt towards her “gatekeeper”.

“It’s bad that one man has tae choose who gets [methadone] and who doesnae. . . he’s not a very approachable man tae talk tae. An’ a don’t like... particularly like men . . . So, I’m just no’ going tae talk tae him, he’s a horrible man. . . I’ll just end up punching his lights oot. So, I’ll stay away fae him.”

(F028 – waiting/wanting methadone)

Although assessment was identified as the most vexed area of ‘workup’, there was also recognition that reform of the assessment process presented great challenges to the prison service. Responding to a question about how he would reform the assessment procedures, one prisoner tacitly acknowledged what a difficult task prison addiction teams faced.

“You would just need to know the person really well and know your job and be able to tell which one was taking the piss and which one wasnae.”

Tactics to accelerate assessment

Prisoners commonly responded to what they interpreted as flexibility built into the PMMT system with a variety of ‘tactics’ to improve their chances of getting prescribed methadone. Suggestions of ‘how to get on MMT’ varied greatly between different prisoners.

Feigning injecting behaviour or medical conditions

Based on an understanding that the addiction teams wanted to minimise the spread of blood-borne viruses, many spoke about the practice of fabricating evidence of recent injecting behaviour in the hope that this might accelerate the process of getting onto methadone.

Some thought that feigning medical conditions would accelerate their progress through the system.

“I’ve actually seen guys taking a dummy fit.....they’re dummy ones, basically they cannae handle life with the withdrawals side effects, cravings and all that so they just collapse on the flair and start shaking and sweating...the nurse, usual scenario, check their pulse and all that.....So I know, their either getting back on their script or they’re getting a detox, I’ve seen it happen to quite a few of them.”

(M036 – wanting methadone)

Violent or vociferous behaviour

Others thought that employing violence or being vociferous about a request might be an effective strategy to improve their chances of getting PMMT.

*“It is not concrete, some guys will come in and they will kick a **** up about it and they will get it. Other guys like me, I come in and I had all sorts of dirty urine, but because they knew me and I kicked up they just gave it to me to quieten me down. But other guys are coming in who arenae maybe as boisterous as I was and they are just saying to them “right you have got a dirty urine here you are not getting nothing”, and they are accepting it and just walking away.”*

(M001 – on methadone).

Others preferred persistent and vociferous behaviour to ensure that those making the decisions about PMMT did not forget about them. These individuals talked about seeing members of the addictions team on a regular basis or using the complaints procedure to further their cause. Most who undertook these tactics seemed to subscribe to the theory of this prisoner who stated:

“My philosophy about prison is, see the worse you are in prison the better thought of you are. . . that is a true to God fact about prison life. The more you kick up a fuss the more you get.”

(M101 – not wanting methadone).

“Toeing the line”

Others thought that toeing the line and being seen to be involved with the help on offer for drug dependent prisoners, other than methadone, might aid their cause. Another tactic involved enlisting the support of an individual member of prison staff or ‘influential’ individuals in the community to advocate on their behalf during the workup process. Finally, some prisoners believed that they were treated favourably in the workup procedure because of their position as drug dealers within the prison.

“[They] fast tracked me. Got me on it [methadone] straight away, cause of all the history and all that . . . They knew I was using . . . [and] I was bringing a lotta drugs into the jail . . . So they knew it was in the best interest tae get me on it straight away.”

(M009 – on methadone).

Providing intelligence

There were many comments made concerning the interaction between giving officers intelligence about the drug scene in prison and what happened to a prisoner's methadone script, whether it be lenient treatment after taking other drugs on top or alteration of a start date for a methadone script.

One prisoner described being approached concerning the start date of his MMT and told that this could be brought forward in exchange for some intelligence about some other prisoners' drug use.

*“See when they put me on methadone they tried to get me to stick it to this one, stick it to that one. That is what they try and do..... “Your methadone is starting in 3 month but I could maybe get you on next week. See *** there how does he get his heroin in? Do you want the methadone tomorrow or do you want to wait 3 month?”*

(M010 – not wanting methadone)

Falsification of urine tests

In some of the establishments, some of the time, prisoners were required to provide two positive urine samples to be allowed to start PMMT. This was a system that was easy to abuse. Prisoners with a lesser habit could use urine from someone who had recently taken drugs to produce a positive sample, and therefore infer that he had a greater drug habit than he actually did to get on a PMMT script.

“It is easy to get methadone here, it's easy. It is unbelievable, all you need to do is give them two drug tests, two failures at a drug test and you can do that no bother, even if I have not had a charge and you have, I will come to you and get a bottle of piss off you, and take that away with me for the test. You get a wee bottle you know and just kid on you are doing a piss and pour it into a cup and gee them it. They will send it away and it will come back positive for opiates. So that is once so the next week you go back again and you do the same again. And that is you on methadone. For how ever long you want. That is no right you know? There are guys who do need it that canny gee them positive drug tests, or who when they do get positive they don't come near them. It's wrong.”

(M006 – not wanting methadone)

Despite the variety of ‘tactics’ to get on PMMT, none of those interviewed believed that any guaranteed success in the workup process. Some prisoners seemed, inexplicably, to be fast tracked onto a methadone prescription whilst others seemed just not to get it. Indeed one prisoner, who could clearly not see any structure to the process put it down to ‘*there just being favourite cons*’.

Inherent contradictions

There was a commonly held belief amongst respondents that elements of the PMMT system, a system with therapeutic aims, also contained punitive elements. These ‘inherent contradictions’ were found in all establishments and generally did not relate to one prisoner type more than another. For some, concern about them acted as a disincentive from further pursuing steps towards PMMT. There were a number of different examples of these.

Consequences of exposure of drug use status

Firstly, some prisoners spoke about their anxiety that requesting PMMT meant exposing themselves as a drug user which, in turn, they feared would have real consequences for them and often their family. These interviewees were concerned that providing a positive urine sample could adversely affect their chances of obtaining privileges, paroles and sentence progression. One prisoner described a tentative mood amongst some prisoners about approaching the addiction services for this reason.

“Just now a lot of inmates are hesitant tae approach Cranston [because they] need tae expose themselves for using drugs. And that could count against them with members of staff in here and progression through the system.”

(M003 – forcibly removed from methadone).

Another prisoner complained:

“You get a thing in C Hall called a father and child bonding visit . . .at the weekend or a Saturday morning . . . they’ve got . . . a special . . . bonding visit fae your kids . . . but they gave us a letter last week that we had tae sign, saying that if we gee a positive drugs test you would be put aff their father and child visits. I don’t agree with that... because I’ve gotta drug habit, it shouldnae stop me bonding with ma children.”

(M028 – forcibly removed from methadone)

Many respondents did not believe that there was any meaningful separation between prison residential and health staff. As a result there was little faith that information given on drug dependency issues would remain out of reach from security and residential staff. Many believed that the sharing of information about prisoners between staff led to problems for prisoners, for example in the form of unwanted staff attention at visits. As one prisoner put it:

“You wait for 6 month tae go on the meth, it’s mair trouble than it’s worth....you need tae provide positives and all that at first. When you start providing positives you just bring a lotta hassle upon your self...they’re gonna start jumping on tap of your visitors.”

(M009 – on methadone)

Strained doctor/patient relationship

Secondly, some respondents believed that PMMT placed a strain on the doctor-patient relationship. Individuals, like this prisoner, compared and contrasted their relationship with their doctors in the community and in prison:

“Say I was stabilised, just for a couple of months, and I started using again and I [say] to my [community] doctor, ‘by the way, I’ve been using for the last seven days . . .and I’m starting to feel ill’, she’ll . . . [say], ‘right I’m putting you up 10 ml but don’t use because after that I’ll be doing dip tests’. [But] you could never say [that] to the [prison] doctor.”

(F022 – forcibly removed from methadone).

Essentially, these respondents feared that whilst they could be honest with their community doctor and expect professional help, patient honesty with the prison doctor might result in the cessation of PMMT.

Urine testing

Another contradiction lay in the arena of urine testing as part of the assessment for PMMT. In some establishments prisoners were asked to produce clean urines before going on PMMT. The ability to provide clean urine samples was supposedly a demonstration of their commitment to stop taking drugs and therefore their suitability for methadone maintenance treatment. From a prisoner perspective they found

themselves asking for help with a drug problem but being told that they could not receive help unless they stayed away from drugs. Those affected by this request believed it to be counter-intuitive and protested that if they could stay off drugs they would not be needing methadone. Some respondents complained that it was nonsensical to ask a drug user to produce a clean urine sample before allowing them PMMT.

“I seen the doctor a couple of times. He asked me to stay clean for five days...then they’d take a sample and if it was clean I’d get put on methadone, because that was me willing to show that I was able to stay off the heroin, tae get the methadone. But the drugs counsellor and me were thinking well the whole point in me taking drugs is because I cannae stay clean, so he told the doctor that and ...the doctor thought aboot it and he put me on it [PMMT] two weeks later . . . I think that’s daeing things a bit back tae front.”

(F005 – on methadone)

Conversely, the need in other establishments to produce two positive drug tests in order to be considered for PMMT had its own contradictions.

Producing a positive sample could result in punishments that were recorded in a prisoner’s records and which affected many aspects of prisoners’ lives. Moreover, some respondents believed that those on PMMT were at a disadvantage because they were subject to increased testing and any positive results (including cannabis) went into their reports. As this prisoner complained:

“When you first start methadone and you’re asked tae submit tae voluntary drug testing on a weekly basis [so]... that they can monitor [you]. . . . If I go doon an I gee them a coupla positives, that goes on ma record which puts me at a disadvantage [compared to when] . . . I’m not on methadone . . . [and] I could go through ma whole sentence without a drug test.”

(M003 – forcibly removed from methadone).

This latter scenario also carried with it the “threat” of having a methadone script removed for a positive result after voluntary testing. This was a strong motivating factor for falsification of drug tests.

Consumption and diversion

Consumption

The logistics of dispensing methadone within prison presented great challenges to prison authorities. Prisoners described different arrangements for dispensing the methadone in each prison and often in different halls of the same prison. These arrangements depended on numbers of prisoners on PMMT, staff available to escort the prisoners, layout of the prisons, and availability of secure facilities. Dispensing times varied from first thing in the morning to later in the day.

Prisoners were aware of the specific problems caused by dispensing methadone in prison. They recognised that prison facilities were not designed for this task and that it placed a strain on staffing resources. However their main concern was when methadone was dispensed rather than where and how it happened. Many prisoners complained about the unsettling effect of not knowing when methadone was being dispensed. One respondent was clear about this issue:

“I like to have my methadone before I start anything in the mornings, cause I cannae function right without it. [I] don’t want to work if I’ve no goat it in me, I don’t want to talk tae anybody if I’ve no goat it in me.”

(F004 – on methadone)

Not all respondents subscribed to this opinion.

“Really, what time of day you get it, that doesnae really affect you. Because wance you’re stable on it you won’t feel withdrawals anyway.”

(M028 – forcibly removed from methadone).

Although there was no dispensing time that suited everybody, the majority of respondents did appear to prefer a morning dispensary time. Most (not all) cited psychological factors, usually mentioning their familiarity with having to score heroin or pick up their community MMT in the mornings.

Others stated that getting methadone in the morning would fit in better with their working day in prison.

“You want your methadone so you can get in about your work.”
(F001 – on methadone).

Perhaps the most important point of all to prisoners was for methadone to be dispensed at the same time every day.

“You need the routine with the methadone, keeps you going . . . If you are a drug user, I would need to go out to score. You need a routine just the same when you come off the smack and go on the methadone.”
(M047 – on methadone)

Some respondents observed that irregular dispensing times might even, in some cases, lead some on PMMT to go chasing drugs.

“They mess up the times a lot. I would imagine that they would have to give people methadone at regular times to keep them stable . . . but actually they gave them it first thing in the morning one day and [in] the afternoon the next day, and you see them, they are all feeling ill 'n' that because of it...they've not got it and . . . you see them running around the landing chasing drugs as well. . . Their heads turn to drugs again.”
(M018 – not wanting methadone)

Diversion: ‘holding back’ methadone

The practice of ‘holding back’ methadone occurred when the individual being prescribed it did not consume it but rather held it back for another person. One prisoner described how this could be done:

“They can keep it in their mouths . . . and spit into a cup . . . or there are people that take a bit of sponge or something . . . put it at the side of their teeth but now . . . when you take the methadone you need tae drink the cup of water . . . or they will speak tae you . . . and you cannae really talk with a mouthful [of] methadone.”
(M045 – wanting methadone)

Reports of ‘holding back’ methadone were relatively rare and this practice could be eradicated by making those on PMMT drink water after ingesting methadone and getting staff to check their mouths. One interviewee stated that leakages were more likely from prisoners who were detoxifying rather than PMMT ones.

“At the dispensary . . . I see more guys trying to swap their detoxs than [their] meths.”

(M035 – on methadone).

Responding to questions about why individuals held back methadone, three main scenarios emerged. Firstly, this practice occurred as a result of bullying and intimidation. One non-drug using respondent recalled:

“[One] boy that was in with me . . . was scared . . . because he hadn’t saved his methadone for somebody . . . the boy was only 19. When he came in at first his first couple of weeks he got a lot of drugs through the visits . . . but the minute he started to cut down they turned against him . . . because he didnae have drugs they wanted his methadone off of him.”

(M021 – non drug user).

Secondly, ‘holding back’ enabled those receiving PMMT to sell or barter their methadone to pay for heroin or drug debt. These individuals treated PMMT as a form of insurance to use during periods of scarce drug supply. Finally, some on PMMT reported that they held back some methadone to help out other prisoners.

“I had a friend . . . in the hall there and he had been withdrawn and he hadnae been getting any kind of detox . . . and I felt sorry for him there and kept him some meth back.”

(M043 – on methadone).

Monitoring

Monitoring comprised three components. The first was quantitative urine testing of which there were two types: dipstick of a urine sample and testing to MDT standards. Urine testing had several functions: to monitor the level of methadone in the prisoner (was the prisoner holding back any methadone?), to monitor the presence of other drugs and for ‘safety’ purposes; the SPS may be in a difficult position if a prisoner

overdosed whilst on PMMT and was found to have been using other drugs too. The second component was psychological monitoring: this took the form of meetings with addiction staff to discuss the psychological welfare of prisoners on treatment. The third consisted of intelligence from prison officers about the behaviour of inmates in their halls. This latter type of monitoring was done on an ad hoc, informal basis.

Interviews with staff revealed that monitoring of prisoners was haphazard and even chaotic across all establishments. There were often no apparent systems in place, and different members of staff in the same establishment did not always concur on what the practice was. Staff were confident, however, that they understood what was needed to provide a suitable level of monitoring but lacked the resources to achieve it.

Responses from prisoners echoed those of staff and also exposed a monitoring system in disarray. The bulk of prisoner comment concerned the area of urine testing and, to a lesser extent, the role of residential staff in initiating urine testing based on suspicion. Prisoner feedback indicated that the second component of prison monitoring systems, 'psychological monitoring', was almost non-existent.

“There’s nothing, just your methadone . . . the nurse that hands you the methadone and she will just ask you how you are.”

(M045 – wanting methadone)

As regular counselling to monitor how the individual was coping, or not, whilst they were on PMMT was conspicuous by its absence across the five establishments. When reflecting on monitoring issues, prisoners’ responses tended to concentrate on urine testing and its consequences.

Urine Testing

Inconsistency of urine testing

The first point that many respondents made was the inconsistency they experienced in the frequency of urine testing in different SPS establishments.

“[At another prison] . . . you’re only urined when the screws ask . . . there’s nae set urine thing . . . Its based on what the screw thinks on the flat. If he says, or you go tae a visit and he thinks you’ve swallowed something at a visit, they will

put you forward fae a urine, if you get a positive urine you get kicked aff it . . . Up here you get urined every week no matter what, but see if you give them clean urine samples fae 6 month they give you it monthly; you get urined once a month, you get leniency, but if you give them 3 positive urines you get kicked aff your meth."

(M008 – on methadone)

"You don't feel under pressure . . . here, see like going tae the health centre and saying tae your self 'am I ready?' . . . in case they pull you fae a urine cause its only once in every blue moon they dae that here.. In (another prison), every week they're usually doing urine samples . . . I've had one doon here . . . [in] 5 month . . . [it's] a lot better . . . here. . . cause your no' feeling nervous all the time."

(F029 – on methadone)

Not all prisoners agreed that infrequent testing was a positive strategy and some attributed the lack of testing to a lack of resources.

"..Aw ... it disnae affect me, ...I'm no taking kit right so it disnae matter, they can gie me wan everyday its not gonnae bother me, it's no gonnae affect me but I think it's the money, that's why there no daeing it, I think it's the money...I think that's what it's coming doon tae, tae be honest with you. Used to get MDT constantly and I've no had wan in 7 months, come on, what's happening, you should be getting wan shouldn't yeh?"

(M035 – on methadone)

"To me they don't test enough folk..... you know I've been in here 2 years and I think I've been tested wance, but then they know me, I can see where they're coming fae, but then, och I don't know, I suppose I could be hiding it, the fact that I am taking drugs, [but] I mean look at the state of some of them they couldn't hide it, ah! you notice, it's kind of diabolical tae hide it, they know, they know who tae go for. I mean the place is all cameraed up, they see who's running roon about all the doors after the visits to try and get their drugs, but they don't test them enough, to me they don't. If they go on a methadone

programme, right then they should be tested at least wance maybe twice a week to make sure of what they are taking.”

(M021 – non drug user)

Inconsistency of urine test results

A second area of concern about testing was the inconsistency in the outcomes of cases involving positive urine tests. In particular it was believed that the dip tests were unreliable, an opinion with which many staff concurred. One prisoner thought that, as a result of unreliability, one might be able to challenge the result of a dip test, whereas with an MDT that would not be possible:

“If you’re caught with something in your urine with a dip test, I don’t think they can strike you off, but if you get caught with an MDT I think they can . . . its like the mandatory drug test’s 100% doon the line sort of thing . . . [if] you’re caught with. . .a dip test . . .you could . . .argue the case sort of thing.”

(F003 – on methadone)

However, despite their unreliability there were instances of prisoners being removed from PMMT on the basis of a dip test result.

Urine testing as a result of “intelligence”

Testing that resulted from hall intelligence was also frequently commented on.

“If the staff see you oot your face, the next day you’ll be put in for a MDT.”

(F009 –wanting methadone)

Many complained about what they viewed as the injustice of being tested on this basis, the implication being that this aspect of the system was open to abuse. In contrast, other prisoners made the point that the monitoring process could be further improved if residential officers were more involved. These individuals believed residential officers were best placed to get accurate intelligence on PMMT prisoners who might be ‘topping up’.

“.....These screws know everything that’s happening ‘cause all they do is stand on the landing,..... they stand there all day and just look, so there gonnae see [the] people all around about that are selling; they know that there’s drugs ...here.”

(M032 – on methadone)

“I would ask the screws for intelligence to see if they are running about looking for it every day. And if the screws gave me the feedback, there he is....., the drugs tests are showing positive.”

(M027 – on methadone).

Falsification of urine tests for monitoring

Prisoner feedback also outlined the consequences of having a ‘monitoring’ system in turmoil. Their main observation was that strip searches were not being conducted thoroughly prior to urine testing. This meant the results of these tests were easily and frequently falsified. The end result of this was further undermining confidence in the system of urine testing. Across all establishments the methods used to falsify tests results were similar. In general it was believed that if tests were performed on urine ‘handed in’ to the health centre these could very easily be falsified.

“...they are just coming in the morning and saying “Pee in that bottle”, ken what I mean, you need to go to the toilet, but most people have got a sample with them, a clean sample, from somebody else that’s no’ had anything, ken whit I mean?”

(M048 – not wanting methadone)

Falsification of MDT tests was a little more difficult. This could be achieved by the prisoner concealing a bottle about their person. This would be punctured to release another prisoner’s urine.

“People carry samples about with them 24/7, just in case that happens . . . when you go to an MDT you get strip searched but you’ve got it somewhere that they’ll no find it. . . when you’re giving a sample your back’s to them so you are just pouring into the sample bottle . . . Most of them on meth carry a sample just

in case. They are no going to find it unless . . . they are really giving you a full search.”

(M048 – not wanting methadone)

Leaving urines in the testing toilets was another suggested method of falsification of the system.

“I think some lassies leave urine in the toilets for lassies that think they’re gonnae get tested, the wans that are clean.”

(F007 – forcibly removed from methadone)

Some respondents felt angry that this practice was occurring. One such individual complained:

*“How the f*** . . . should [they] be able to hide that bottle and get away with that I don’t know . . . That should never happen. You should have been watched, taken into a room and strip searched. If the guy wants onto it [PMMT] he’ll take a strip search”*

(M035 – on methadone)

Effect of urine testing on drug behaviour

Another adverse effect of urine testing, according to a few, was that testing could cause prisoners to adversely alter their drug taking behaviour. As heroin was attributed with being more readily flushed out of the system compared to cannabis, then the former was the drug of choice for those seeking to evade testing.

For some prisoners, urine testing was regarded positively and seen as a good incentive against “topping up”.

“If your on the meth, you’re getting drug tested, you’re getting positive, you’re getting aff it [PMMT] fair enough...It’s a good wee incentive tae stay aff it.”

(M038 –wanting methadone).

“Urine testing on people that are on methadone is a great incentive. . . I’ve got a friend that’s on methadone, and would never touch any drug in the jail cause she’s that scared cause she’s on a high amount of methadone that she’ll get

struck off it 'n' that she'll be ill [as a result of withdrawal]. That is keeping her away from other drugs."

(F006 – wanting methadone).

Non-voluntary reduction

Prisoners were just as effusive in their criticisms about the management of 'non-voluntary reduction' as they were about urine testing. Non-voluntary reductions occurred when someone was removed from PMMT after testing positive for other drugs. Chief amongst these criticisms were perceived inconsistencies in the handling of cases of non-voluntary reductions.

Inconsistency of non-voluntary reduction

"If you come in with a dirty urine then you do not get your methadone right? But . . . plenty of lassies come in with dirty urine and still get their methadone right? I have been in and out this nick since 16 year old, I have been off the smack for 2 years. First offenders can come in off the street with smack, all sorts in their urine and they still get it . . . It is just if your face fits basically."

(F023 – forcibly removed from methadone)

The punitive effects of testing was one that was frequently commented upon. Some prisoners felt that, rather than punishment, a negative test, whether or not the person was receiving methadone, should be used as an opportunity to help the prisoner.

"...If they do they MDTs on them and they've got heroin in their systems, then I think trying to get them on the methadone or anything like that would be a better opportunity than like punishing them ... 'cos it's like an illness..."

(F018 – on methadone)

*"The last drug worker that was in here she was always threatening to take you off it if you didn't stay off the drugs and all that. Whereas if you failed a drug test obviously I think they should ****ing try and help you rather than threatening you with the garden stick. Take your methadone off you if you don't stop, we will tell you what to do, know what I mean? She threatened to take me off it, I said "take me off it". She took me off it for 8 days and I was ****ing in some pain with it know? It is one of the worst drugs I have ever come off... You can't just have a drug habit for 20 years and then all of a sudden oh there's*

methadone, stop. It does not work like that. The last drug worker we had was, she was going like that to you, "you will have been on it for 6 months, you should be cured." I don't think that is right."

(M004 – on methadone)

Unsuitable detox programmes

'Non-voluntary reductions' were also often condemned on the basis that the detoxification programme that usually accompanied them was unsuitable. Commonly the dosages and time duration typical of a prison detoxification were felt by many prisoners to be insufficient.

"A detox is nothing. All you get is like 3 valium and 3 dfs [dihydrocodeine] for a full day, that is nothing compared to if you are on methadone and . . . heroin and all. It is just no there for you, doesnae even touch the sides."

(F013 – wanting).

"When . . . your detox, [is] just finishing . . . the withdrawals from the methadone's just kicking in, kind of thing. So it does help you for maybe that first two weeks . . .after that, that's when it really kind of hits you."

(F008 – not wanting methadone)

"Double punishment"

There was an almost universal acceptance amongst respondents (prisoners and staff) of the consequences of being taken off PMMT. In particular, the practice of removal on admission was widely criticised as being counter productive and a form of 'double punishment'.

"Being in jail is bad enough without being punished again by getting taken off yer methadone, the only thing that is kinda keeping ye sane."

(F020 – forcibly removed from methadone).

"The thought of getting prison alone is a shock to the system never mind your medication getting ripped off you that is why you end up running about the hall trying to get other drugs, which is defeating the purpose of the detox to start with."

(M014 – wanting methadone)

Lack of support

The aftermath of such action was familiar to all respondents: a resumption of chasing heroin, which brought with it associated difficulties for the individual, their families, other prisoners and the prison as a whole. Some complained that the addiction team offered no support to those facing this.

“You get nothing. . . nae sort of help whatsoever . . . nae counselling . . . nothing at all to help you as far as your drug habit goes.”

(M001 – on methadone)

Health consequences

Others pointed out the physical and/or mental health consequences of rapid reduction.

“So I see the doctor the next day and he says this and that . . . Still no methadone, still waiting . . . Then I had the mental health officer down . . . I put all ma eggs in ma basket with him really . . . he thinks I’ve got two doctors on my side and him on my side and that I should be getting methadone, as I was prescribed methadone . . . for two reasons: one I’m on heroin obviously and another, it helps my [mental health problem] . . . and I don’t wanna go back to [that].”

(M019 – forcibly removed from methadone)

Disincentive for PMMT

More, still, believed that rapid reductions acted as a disincentive against going on PMMT (see “Why prisoners don’t want PMMT”, Chapter 4). Almost without exception, prisoners’ views on ‘stopping methadone’ was that all should be given a chance on entry to prison. After this, a positive test would justifiably warrant ‘non-voluntary reduction’. Prisoners were also clearly of the view that they should not be allowed to abuse PMMT. Above all, there was an acceptance that the process of ‘getting stable’ on methadone was a complicated one. Expanding on this theme one prisoner noted:

“I wouldnae take people off their methadone so easily . . . try and help them through their methadone . . . give them 3 strikes . . . it isnae just a one hit wonder, it's a process to help people and I know that more than most . . . with all the attempts . . . of trying to come off . . . so to help people use it as a tool

rather than just putting people on it and leaving them to it . . . I think they should be progressed after they put them on it.”

(M018 – not wanting methadone)

Opinions like this one were not uncommon. They tended to grow out of drug dependent prisoners’ comparing and contrasting the differences they experienced in the protocols typical of community methadone programmes (more flexible) and those used in prisons (more strict). They knew only too well that many people being maintained with methadone in the community still used other drugs and that stopping using drugs was not the only measure of success of community MMT. They were aware that ‘success’ of community MMT was also measured by significant reductions in the use of other drugs, better relations with family, and better possibility of working and or going to classes. One prisoner recalled his experience in one prison of trying to reduce his daily dosage of methadone. During this time, he used on top, tested positive and as a result was removed from his script.

“You dinnae get a second chance in here . . . usually outside at the drug problem centre when you give them a urine sample. . . [that’s] contaminated with heroin . . . they sit doon and they talk to you and . . . say. . . obviously your not coping with say you’re. .. 50ML . . do you want to get put up to 60, do you know what I mean? Outside they will work with you and make you stable whereas in here if you get caught once, you’re done.”

(M045 – wanting methadone)

Dose reduction

Alongside the inappropriateness of detoxification, some respondents also found fault in the process of reducing their daily methadone dosage. These were individuals who were essentially doing well, were stable on PMMT and wanted to start the process of reducing their daily dose of methadone. One such individual described his experience of working with the addiction team with the aim of reducing his daily dosage of methadone:

“I wanted tae dae it about 2 ml a week . . . he [member of the addiction staff] says ‘well we actually like tae dae it maybe 3 ml a fortnight, how do you feel about that’ I went aye well I’ll try that then. So he wrote that down and that

was fine . . . I went away so I thought I'll no' be dropped again for a fortnight . . . the following week I got dropped 3 ml . . . the next week I think I got dropped again. . . I thought naw . . . ye cannae dae that with me because I wisnae sleeping very well . . . so I says tae them I just, I want to stick at the 50 [ml] the noo, until ma body gets used tae this . . . then when I dae feel ready. . . I'll discuss it with you . . . they don't discuss things with each other. . . [if] it'd been wrote in a book, and they actually read the book every day they would [know] that I wisnae to be dropped for a fortnight, ...no' dropped again the next week, and then dropped again the following week. . . I'm on 50 the noo and I've just put a stop tae it, cause I cannae be bothered."

(F003 – on methadone)

This account was one of making progress on PMMT, which was then halted due to poor communication between members of the addiction team.

Positive effects of non-voluntary reduction

A few respondents did reflect positively on the event of being removed from PMMT. These individuals responded to this crisis by managing to move on from their drug habit altogether whilst serving their sentence. One such prisoner explained that for him the divide between taking methadone or heroin did not exist as it was just replacing one addiction for another.

"They gave me the test and it came back positive. . . they asked me what happened . . . there is a lot of guys in here that say "my dog died outside I had to use", and I says "listen at the end of the day I used and I got caught if I am gonnae get kicked aff the methadone so be it." And I have never felt better since I have been aff it because I don't bother with drugs noo but I am at PT twice a day. . . now . . . I am brand new, I can actually say I feel good noo for the first time in years."

(M042 – forcibly removed from methadone)

CHAPTER 6. STAFF ATTITUDES TO AND PERCEPTIONS OF PMMT

The findings in this chapter were evidenced by two sets of views, that of the staff themselves and that of the prisoners. Throughout the study, the prisoners' views on the attitudes of staff were in agreement with those expressed by the staff themselves. Staff attitudes and behaviour and prisoner perspectives will be explored before considering staff training and the staffs' perceptions of the effects of methadone in prison.

Staff attitudes

Attitudes of staff fell broadly into three categories and many of their perceptions of the effects of methadone followed from these. Firstly there were officers who had compassion for drug users, who saw that methadone could offer these people some help. On the other side, there were officers who resented drug users and considered that was it the drug users' own fault that they were in their position of desperate addiction. These officers tended to be anti- methadone. Somewhere in the middle were officers who were happy to go along with methadone, not from the prisoners' perspective but rather their own; their jobs were made easier by putting 'junkies on methadone'.

The majority of staff and prisoners thought that about half the officers cared about prisoners and half did not.

“The general attitude of the prisoner officers towards methadone is probably 50:50 for and against.”

(Staff 001)

“He's just a very a spot on guy, he does everything in his power to try to help you, 'n' he really understands where you're coming fro, so it just goes to show, you get good and bad..”

(F002 – forcibly removed from methadone)

Positive attitudes

Being caring involved being open and able to be confided in, someone with whom the prisoner could be honest, without fear of reprisal. This normally included the ability to tell them that they had been using other drugs on top of their methadone.

“[named staff member]’s...good... does help. I’d be honest... I’d just say look.. I’m using, because it’s confidential.”

(F022 – forcibly removed from methadone)

The staff that had a more caring attitude towards prisoners tended to be more pro-methadone than the staff who had a less caring attitude.

“I can spot somebody that has been using drugs and I will certainly say you are needing to sort yourself out. I try and direct them to an area where the expertise is. I certainly don’t have the skills myself, but I want them to get help and encourage them to seek help. That is the way I do it.”

(Staff 004)

In general, staff working in the addiction units were much more caring about and understanding of drug users. Many key workers from addiction units tried their best to help drug users and this was often appreciated by drug users. However, such staff who could be positive about methadone and drug users were in the minority.

“I am positive about it I think it is a positive thing. Although, I am a lone voice sometimes.”

(Staff 010)

Negative attitudes

Staff who had not made such a career choice to work with drug users often found it difficult, dealing with drug users and methadone.

“Some of the staff don’t want to know; they don’t want to work with drug users.”

(Staff 006)

Prisoners were aware that for some staff there was an inescapable stigma attached to just being a prisoner, however, the stigma of being a drug using prisoner was generally worse.

*“They kind of look down on us. Some of the screws, up here they think I’m just a mad f***ing junkie. Some of them look at you like you are a rodent.”*

(M008 – on methadone)

There was a strong anti-drug feeling amongst many prison officers, many of them were demoralised by the seeming lack of advancement in many prisoners who did not seem to be making an effort for themselves, despite help being available in the SPS. Methadone was often just another part of this picture and the stigma that surrounded being a drug user was, at times, carried over to those on methadone. Although some staff saw drugs users differently from those on methadone scripts, some did not.

“Some staff are very derogatory, they say ‘it’s OK for them junkie B’s. We are giving them what they want’, you know, really derogatory comments like that.”

(Staff 001)

“Most prison officers if they are honest are quite anti drug, quite anti. Whether it is methadone that is going to help them or a detox it gets quite demoralising when you are in it and you see everything that is in place to help them and they still abuse the system... If everybody’s honest they probably have quite a negative view of drug users. It doesn’t matter how much support they get, very few, very few will be positive and responsive to that kind of help and treatment.”

However, if drug users were seen to be ‘toeing the line’ this appeared to increase the chances of experiencing positive attitudes from staff.

“I get a lot of feed back from staff and I think it's like a pat on the back.”

(F014 – on methadone)

Many staff thought that a drug user’s addiction was his/her own fault and prisoners were aware of this view. Staff members with this opinion had a complete lack of

empathy to drug users, with the underlying belief that these prisoners had chosen that way for themselves.

“You get dinosaurs, who are still of the opinion that hell mend them its up to them [the drug users], they’ve got themselves into this mess so they can get themselves back out.”

(Staff 012)

“The way they see it is nobody made us be like that, we made ourselves be like that.”

(F010 – on methadone)

“They are nurses, they are here to help us. But as far as they are concerned it is our fault, right?”

(F023 – forcibly removed from methadone)

Along with these feelings from staff came resentment at the cost of treatment. As law abiding taxpayers, many prison officers resented money going to give methadone to drug users in prison who were considered to be just abusing the help.

“Why are we giving them free drugs and they are nothing but prisoners who we are spending public citizens’ money on?”

(Staff 011)

“They’ve got to rely on something and methadone is that something to the cost of the law abiding citizen outside.”

(Staff 002)

*“You get a bit of an attitude with some of the staff, they think we’re f***** tax payers, we’re paying for this.”*

(M035 – on methadone)

Officers with this attitude often described methadone as a drug-user’s crutch, they thought that drug users had no intention of ever coming off methadone and being prescribed methadone was like being given a free ‘charge’ that removed from them the trouble of getting drugs in through visits.

“Methadone is just a kick that you can get in a day that you don’t have to work towards, they don’t have to try and arrange to get it through a visit.”

(Staff 013)

Both staff and prisoners described a hard core of prison officers who still believed in giving drug users nothing and many wanted MMT stopped.

“You get the sort of hard core of prison officers who still believe in giving them nothing.”

(Staff 012)

“I think there is a hard core of screws in this jail who want methadone stopped, and they are doing everything they possibly can tae get it stopped.”

(M003 – forcibly removed from methadone)

“I don’t agree with methadone at all.”

(Staff 011)

It was not just residential staff who were reported to have these attitudes, nursing staff, too, were reported to be against giving prisoners methadone.

“They just don’t like it ‘I think it’s atrocious down here the way people’s getting this methadone willy nilly.’...He’s just totally against it, he should not be a nurse, he’s just not a compassionate person at all.”

(F002 – forcibly removed from methadone)

Such staff often viewed prison as a place for punishment and were often disgruntled generally about working in prisons. Such negative attitudes appeared to completely prevent some staff from being able to consider rationally the possible benefits of methadone and sometimes appeared to cause staff to act in unhelpful ways.

“If they are against it then they don’t see the benefits cause they don’t want tae see the benefit of it.”

(Staff 012)

An addictions officer commented that no one in the prison seemed really to care about the prisoners; financial concerns were more important. In one establishment the governor was cited as never being in the addiction unit. One addictions officer had not met either of the present or previous governors of the establishment.

“The previous governor never stepped foot in this building, He never spoke to any of the addictions team and the new governor is exactly the same, I have never seen him, I have never spoken to him.....I think the bottom line is that their eyes are off the ball really. The prisoners in here, nobody gives a shit, not really. Too worried about making savings.”

(Staff 006)

This lack of care for prisoners was also demonstrated by the focus of the concern over inadequate monitoring of methadone consumption. Should an overdose occur then the concern was that the prison staff would found to be lacking, not that a prisoner’s death should have been prevented.

“The numbers have escalated so much that we can’t, I can’t possibly test the amount of prisoners that need tested. So prisoners can go weeks without a drug test. The screening process should be done because if these guys are abusing it, it’s dangerous. For the prisoner, chances they overdose. Hope it never happens but it still has an impact on staff. Then it is part of a fatal accident inquiry you know? Questions would be asked...it is the impact on staff.”

(Staff 004)

Sometimes an attitude of disinterest accompanied resentment of drug using prisoners.

“I’ve better things to do with my time than discuss methadone”.

(Staff 010)

“There is more to my day than talking about methadone.”

(Staff 011)

Such staff were described as being ‘hardened’ to the situation with drug users.

“All the staff in here, nothing surprises them.”

(F015 – not wanting methadone)

“Many do try to help, but often end up getting ‘bitten’.”

(M021 - non-drug user)

Many officers thought that too many prisoners were on MMT, creating too much work for the staff. They tended to focus on the aspect of the chore of dispensing methadone rather than focussing on or acknowledging its benefits. One addictions officer commented that if prison officers really thought about it they would realise that it does make their job easier in part by calming down the prisoners, however, most of them just complained about how much work it was to take them to get their methadone.

“I think you would find that if they actually sat down and thought about it, yeah it probably does because it is removing the chaos. But I think that some guys think that taking them over to the surgery is just a hassle. Some of them really don’t see the value as well, they just call them junkies.”

(Staff 006)

A resistance to starting people on MMT and hence further increase the numbers was noted by addictions workers.

“To get every case started was a struggle.”

(Staff 006)

Ambivalent attitudes

Some staff did not object to prisoners starting MMT and held more tempered views about methadone. Such views were often held for selfish reasons, however, not for well thought out, philosophical or considered reasons. They would be pro methadone, for example, if it made their job easier but could quickly turn against it if they felt they were being inconvenienced by it. These officers did not want to ‘put up with’ prisoners topping up, or taking other drugs as well as their methadone. However, to remove them from their methadone script would sometimes not be easy for them, either, as the prisoners may then misbehave which actually made their job harder.

“From the officers point of view I often feel it is a case of you are dammed if you do dammed if you don’t. The officers will phone round and say that there is somebody obviously under the influence of other drugs, so you get a urine sample, and yes it tests positive so take them off methadone. Then you will have the same officer two days later complaining that they are troublesome because they are not getting their methadone. So, I feel, what they want is a quiet life. They want them on the methadone, they are happy but they don’t like to see that they have been using on top but, my God, if you take them off the methadone then there is a problem because they are being a pain in the neck.”

(Staff 001)

Staff behaviours

There were a variety of ways in which staff with less than positive attitudes displayed uncaring behaviour towards prisoners on methadone. Such behaviour was reported more by prisoners than staff; there appeared a certain reluctance among some staff to discuss this issue.

Prisoners reported a lack of concern at the discomfort that drug users went through when withdrawing from methadone. In one of the establishments, staff were not concerned to dispense methadone at a reasonable time, they made no effort to get the methadone promptly to prisoners and verbally expressed that ‘they had better things to do.’

“The nurses that dishes it out says they’ve got better things to do than give us methadone.”

(F002 - forcibly removed from methadone)

Some nurses were reported to taunt prisoners that if they did not behave in ‘this way or that’ that they would not receive their methadone. There was a recurrent theme of using methadone for control purposes.

“The nurses say shut up or you’ll not be getting your meth.”

(F022 – forcibly removed from methadone)

Prison officers were often described as victimising certain prisoners, attempting to have them removed from MMT because ‘they don’t deserve to be on it’.

“[They say} ‘We know you’re going to trip up, eh. Make hay while it lasts, cause you’ll no’ be on it long’.”

(F005 – on methadone)

*“The drugs counsellor said tae me when I got put on it, “don’t muck this up because there is a certain member of staff that would like to see you fall and f**k things up for yourself.””*

(F005 – on methadone)

Staff also mirrored these views.

“I can say with my hand on my heart there were some staff that actually seemed to be punishing the guys on medication.”

(Staff 006)

The behaviours of staff varied in nature and this could cause confusion and uncertainty among prisoners. This was demonstrated in the reaction of prison staff witnessing illicit drugs being used on top of methadone. Some staff, clearly seeing prisoners take drugs on top of their methadone, were choosing not to report it.

“The staff are not blind, this is what I cannae understand. They’ll see lassies that are on methadone and walking about the hall bouncing’, mad with drugs and they’ll just laugh it off, and say “I’ll be getting a nurse here to see you, ha, ha, ha.”

(F004 – on methadone)

Other staff chose, at times, to report drug use. Reporting was entirely at their discretion. The prisoner could ‘keep in with them’ and it might not get reported, however at times it seemed that prison officers were pleased to bring about the downfall of prisoners.

“Because I got caught burning....they just appear, screws, and about 45 minutes later I got shouted down to the surgery, and then they say “don’t

bother coming down for your methadone now.” My theory is that they wanted to show that the jails are run by the screws, not the cons.”

(M010 – not wanting methadone)

At times certain staff could thus assume the role of a member of the addiction team, deciding the suitability of the drug user’s behaviour whilst on a methadone script. For example, one prisoner’s officer would only report her if she was not honest that she had used on top, thus the prisoner was entirely at the mercy of their personal officer’s discretion.

*“My personal officer, seeing me rough looking the next day, she’d be like that, “a wee blip?” ..and I’d say ‘yes’...see if a said ‘no’, she would get me MDTd ...just to say...don’t f***** lie to me.”*

(F016 – not wanting methadone)

Staff with tempered views would often make jibes about methadone, poking fun at the prisoners who were on it. Many prisoners commented that the officers shouted out comments such as ‘green mile’ when it was time for methadone collection. Others joked, for example, that there was no methadone that day. In general, these comments were received with humour by the prisoners.

“I think the biggest majority will understand it, like, some of them will have a laugh -they call it the green mile, right?”

(F004 – on methadone)

“Come on and we’ll go fir your jungle juice”, they’re awright, the staff are awright...”

(F021 – on methadone)

However, not all prisoners took the mocking well, some were sensitive and were angered by its unhelpfulness.

*“Members of staff mock “there’s the methadone crew” What the f**k’s that all about? I’m on it to try and help myself you should be encouraging me, and they say “I’m only joking.”*

(M002 – on methadone)

Staff training

In interviews conducted across a range of staff from governor level through to medical staff and residential officers, training, or lack of it, was a much mentioned issue. Staff reported that the change in methadone policy had been brought in haphazardly across the SPS estate and that there had been no formal training for officers.

“It was quite haphazard across the prison service, really.”

(Staff 003)

“Basically it was very, very simple, ‘We are bringing this in here, this is the reason why we are bringing it in’ and blah, blah, blah. And we just accepted that it was up to us to find out about it if we wanted to.”

(Staff 011)

This lack of training meant that many officers were ill-informed about methadone itself, the reason for it being prescribed and the aims of the treatment.

“All we (staff) know is it’s a green liquid that’s a substitute for heroin. If that’s it, then fine, if that’s all methadone is, a substitute for heroin. . . then I know it all, but I have . . . a feeling that I don’t.”

“There’s a culture all through the prison officers of why on earth are you doing this, why are you keeping someone on methadone for so long and why are we giving them so much of it as well.”

(Staff 012)

Most residential officers spoke about their individual knowledge of methadone maintenance being very much dependent on their own level of interest in the subject rather than any formalised programme of training. Most believed that more training on methadone would be of benefit to them. One such officer commented:

“We [staff] are uneducated [about methadone]. [We need a] basic understanding why methadone has been introduced . . . its benefits for the prisoners . . . how does methadone work, background . . . educate us a wee bit. Train the staff . . . they are looking to restructure our days as well you know. As in less kind of security type work and more prisoner based type work.

Rather prisoners going outwith the hall to do their programmes they are looking to train up prisoners . . . during the day within the hall, within groups . . . If that is the case we would need to be trained up in the addictions side off things . . . I think everybody, all staff should be able to deal with it.”

(Staff 004)

Some officers suggested that if this training deficit was tackled by a more in depth, informed training programme on drug and drug treatment issues they would be better equipped to carry out their day-to-day job. By contrast, two senior members of staff talked about the current level of training on drug dependency and treatment issues for residential officers as adequate to equip these officers for their job.

Staff’s perceptions of the effect of MMT on prison life

Staff believed that the introduction of methadone has had a notable impact on various aspects of prison life in general and on the individual prisoners’ lives. Areas described as affected included the risk of blood borne virus transmission, prisoner debt and prisoners’ families debt, relations with prisoners’ families, recidivism, atmosphere in the halls, work parties, doctors’ surgeries, prisoner attitude to the SPS, staff’s jobs, amount of drugs in prison and visits.

General effectiveness of methadone on prisons

The prison service monitors the amount of drug use in prison by the percentage of positive mandatory drug tests (MDTs). Few staff made reference to mandatory drug tests, however one governor cited the fact that MDT figures had improved to support a statement that the introduction of methadone had been a success.

“Our MDTs have reduced, it is not a true figure certainly by any means but you need a bench mark so we go from that.”

(Staff 003)

There was also a belief that being able to provide MMT had resulted in a decreased suicide rate. There was thought to be a strong psychological factor involved here, in that the staff were now able to offer prisoners something when they first come into prison, the time when prisoners can feel desperate and hopeless and most suicides occur.

“Suicides, I think have dropped in response to methadone...Although there is no real way that I could evidence that.”

(Staff 014)

It was also stated that medical clinics were not nearly as busy as they used to be. Although the number of prisoners in one establishment had notably increased, the number of general medical complaints had not. This was attributed to many general medical complaints being a function of chaotic drug use.

“Miles better, masses. I had full clinics when I came here, I’ve always had full clinics. I’ve got a higher maintained population and by rights the routine run of the mill lumps and bumps coughs and colds or whatever workload should have essentially doubled and it hasn’t and I think the reason is most of the things I saw for ailments, mood, stresses, it all revolves around drugs.”

(Staff 014)

Effect of methadone on individual prisoners

When it came to considering what percentage of prisoners were perceived to have benefited from methadone, this depended greatly on perceptions of the aims of treatment. Some staff based their opinion on whether it altered long-term recidivism, others that the prisoners were able to reduce and stop methadone, others that it just helped to stabilise prisoner lifestyles and therefore enabled them to address aspects of their lives other than drugs, still others thought that it must stop them taking other drugs. Despite the variety of treatment aims expressed, many of staff thought that providing methadone was generally a lot better than doing nothing.

“If you do nothing you get nowhere, if you do something you get very little but you do get some doing well and that’s the way I see it.”

(Staff 014)

The many ways in which staff believed that PMMT had affected prisoners at the individual level are described below.

Risk reduction

Methadone was originally introduced into prison primarily to reduce the risk of blood borne infections. Most of the staff interviewed thought that it was effective for this

purpose. Low frequency of injecting is crucial to reduce spread of blood borne infections and many staff thought that there was a reduction in high risk injecting practices as a result of methadone.

“The benefits I see is less intravenous use, less drug sharing, less drug seeking behaviour.”

(Staff 008)

“These guys without methadone are very hazardous drug users. You’ll get a set a works being used by 20 guys and although they think they’re clued up on cleaning and getting it sterilecause quite often they make sets work out of guitar strings and insides of pens and things like that and there’s no way on this earth that they are gonnae clean it properly. So I would rather see these guys on a stable methadone prescription than chasing around after 2 or 3 bags of really poor quality heroin that they are gonnae try and put into their veins through seriously dubious means.”

(Staff 012)

A reduction in injecting and, therefore, probably needles in prison could only be a benefit to staff as well. The presence of needles was perceived as a health and safety risk to the prison officer, whether he pricks himself whilst searching cells or is attacked with one.

“Health and Safety has improved because a question I asked a lot of prisoners is are you jaggig? I came very close to getting a prick during a search and I dread that. Whatever happens, the numbers of those on methadone and jaggig are very small, if any. In that sense alone that is a weight off anybody’s mind.”

(Staff 004)

The reduction in risk of blood borne virus infection attributed to methadone in prison was considered, therefore, similar to the benefits experienced in the community.

“There’s the health aspect where you don’t have as many of people with blood borne viruses sharing your works, you reduce the risk, you reduce the risk of chaotic behaviour, it’s the same benefits as somebody getting a methadone script outside.”

(Staff 012)

Quality of prisoners' lives

Many staff reported transformations in the lives of individual prisoners. In general, these changes were readily volunteered by staff with a positive attitude to drug users but not so by those with a negative attitude. On being questioned on this topic, however, staff with negative views would generally concede that they had noticed a difference in maybe one or two prisoners.

Many of the staff thought that PMMT helped to stabilise the majority of prisoners.

“On the methadone I would say 70-80% have a remarkable change, you know just in their personality.”

(Staff 004)

“In the prison setting virtually everybody stabilises.”

(Staff 014)

Changes in the prisoners' lives came about through the removal of the necessity to chase drugs, the removal of the violence that accompanies trying to secure drugs, stopping debt and allowing the prisoner to focus on aspects of life that were obscured when drugs are the focus. Thus family becomes important again, some might attend education classes or prison programmes. The prisoner would integrate more in prison life and have better social interactions.

Prior to being on methadone, trying to secure a supply of drugs resulted in violent behaviour from prisoners. Staff assaults occurred, at times prison officers would even have to put on protective clothing when dealing with 'drug-crazed' prisoners. This type of behaviour was eradicated with the use of MMT.

“Assaulting staff, jumping over desks to grab letters, obviously he knew there were drugs in them. The staff, going behind his cell I remember going to put kit on because he was threatening to stab us with a syringe and all that and he got put on methadone and he turned round 180° because the chaos was gone.”

(Staff 006)

“He is totally different man. Always in bother, always up on report, always in fights, always somebody's muscle pushing for drugs. On his methadone in here.”

No bother. Gets up, goes to work, comes back and then is behind his door. Still talks to the old group of friends but they would say what a different boy he is.”

(Staff 009)

Often reports of such transformation were accompanied by comments that the prisoner had not abused the help offered by the SPS.

“The positives I take out of it is the guys that are making it work for them, the prisoners, go by the book and the changes I have seen in some prisoners have been remarkable.”

(Staff 004)

By accepting the available help, prisoners could regain self-respect and composure. They were 'freed' from the cravings for heroin and were thus able to participate in constructive activities.

“There was one example, a lifer had done something like 30 years. This guy was lying in such a mess in his cell, just no personal hygiene. Just no self respect whatsoever, see him now he is on methadone, up and about, involved, totally participating. It is remarkable.”

(Staff 004)

In the female prisons, where there was less aggression to begin with, there were fewer reports of dramatic changes in levels of violence or aggression of prisoners, rather PMMT was described as having a 'settling effect'. Officers reported female prisoners saying that now that they had methadone, they were going to stay clean, that is stay away from other drugs and be stable on methadone only.

“They certainly seem a lot more settled and a lot more “well I have got my methadone now.” It is almost like a security blanket for them. I have got my methadone now, I am going to be all right, I am going to stay clean.”

(Staff 013)

Whilst stabilising prisoners was regarded as a positive feature in itself, it was also argued that an important effect of methadone was that prisoners had a chance to be stable when they went back into the community.

“It’s positive if they do come off heroin and they can then concentrate in getting the best out the prison that we can offer which is a lot, i.e. PT, education, prison programmes so that they can be a so called ‘better’ person when they get out and turn from crime.”

(Staff 011)

However, there was little confidence about the extent to which PMMT would lead to stability on release.

“If we put two hundred folk on it, the ones that will do well, do well I mean, not relapse, for a significant period of time and not re-offend, we’ll be lucky if we get ten out of two hundred. It’s not a miracle drug.”

(Staff 012)

“I’d love for somebody to give me a bucket of money and say the girls you start on methadone we are going to be able to track them down all over Scotland over the next two or three years, see who has re-offended, who’s using, who’s attending key-work appointments, who’s got a job, who’s doing this...”

(Staff 014)

Some officers’ expectations of methadone were unrealistic in that they thought that PMMT should change the type of person that the prisoner was. Such expectations tended to be associated with negative attitude to drug users and resulted in the officers’ perceptions of the impact of methadone as minimal and this, in turn, increased their resistance to it.

“So I don’t know if methadone’s made a huge difference to the type of person they are, therefore they would probably use heroin if they did not have the methadone.”

(Staff 012)

Debt

Having a free supply of methadone obviated the need for illicit heroin, thus the prisoners did not need to acquire debts with drug dealers to satisfy their drug cravings. Acquiring debt was perceived to lead to all sorts of problems. As described earlier in

the report, prisoners often involved their families or they could be asked to carry out 'deeds' in repayment. This could involve performing violent acts to others, who perhaps had crossed the drugs dealer.

"What it has cut down a lot, with the methadone, you don't have as many people in debt to the big drug dealers in the halls or the big players that are in the halls."

(Staff 009)

Family

According to staff, contact with families was thought to be affected greatly by drug addiction. At times of contact – visits or telephone calls - the focus becomes entirely that of arrangements about how to either get goods or money into the prison or delivered to a community address to pay for a drug habit. Prisoners on methadone were less frequently heard shouting down the phone at relatives since methadone had been introduced.

"It certainly helps them with their relationships what I no longer hear as often is people screaming down the phone. That used to be very common, people would be screaming down the phone, shouting abuse at their partner or giving them orders of what to bring in and it would be like a new pair of trainers, a new pair of jeans, that is not for them, this is to pay for the drugs. Very rarely now do you hear the shouting and screaming down the phone but that used to be common place."

(Staff 009)

As well as suffering from poor communication and a lack of interest from the addicted drug user, families of drug users are often brought into debt by the prisoner. The family would not want anything untoward happening to their relative whilst they were in prison and they therefore felt duty bound to hand over money, either to community addresses or at visits, to prevent this happening.

"There is a major thing with the families as well, it saves the families getting into debt. There is a major problem with the family, people were buying drugs and getting their families into huge amounts of debt. Again I don't know the

exact price but I think it is double the cost in prison to keep a habit so that is a major benefit.”

(Staff 008)

Methadone was often described as taking the chaos of constantly seeking drugs away and allowing the prisoner to embrace other aspects of their lives, this often involved the ability to keep in contact with the family, and be interested in them, rather than turning all their interest towards getting drugs.

“So I think it improves the family relationships an awful lot if they are on scripts.”

(Staff 007)

Residential halls quieter/decreasing violence

Almost all staff reported that there was a lot less violence in the prison and a calmer atmosphere generally.

“It is positive. There is a lot less violence, a lot less violence.”

(Staff 010)

By putting certain ‘hardened addicts’ on to methadone there was a disproportionate calming effect on the residential halls. Such hardened addicts often wielded chaos through their intense determination to obtain drugs for themselves.

“I could name a lot of hard players that are now on methadone. What a difference. What a difference in the hall and as far as, yeah, if we could put all drug users onto methadone what a difference it would make.”

(Staff 009)

The majority of staff thought that prison officers’ jobs had been made easier because prisoners were less chaotic so maintaining order in the residential halls was easier.

“The officers probably don’t bother about methadone - they’re quite happy if it’s just keeping the hall quiet.”

(Staff 005)

As well as calming the residential halls, introducing methadone also affected calm in other areas of the prison, for example, the visits area. As less drugs were requested to come in on visits so this area had become less frantic.

“As far as the gallery goes, people who are on methadone who would normally be trying to get drugs in, it certainly calms down the visits because a lot comes in on the visits when people try and bring it in then. You don’t have the same tension along the galleryAs far as the drug scene and the hassle that people have using and taking drugs into the prison, it has certainly calmed that down.”

Work

All prisoners in the establishments studied had the opportunity to, or were required to go to, work. Most drug users did not work but some staff thought that when on methadone more drug users went to work.

“Some of them are now beginning to get up in the morning and are going out to work. There is a bigger element of the drug users going to the work party.”

(Staff 009)

Not all staff concurred with this positive effect on work; some thought that methadone was promoting laziness. As discussed previously, some prisoners stated that they had to wait to receive methadone before they could ‘manage’ to go to work. In different establishments, and indeed in different halls in the same establishments, methadone was given out to the prisoners at different times. Sometimes it was not given out until lunch time. Some staff were sympathetic to this, others were angry that these prisoners were allowed not to go to work without getting put on report (penalised).

“Those guys who are on methadone don’t go to their work for some reason in the morning, the majority of them....I don’t agree with that at all.. To me, in my opinion it’s promoting laziness.”

(Staff 011)

Prisoners see the SPS more positively

Staff believed that, traditionally, prisoners thought of the prison service as a place for confinement and punishment. Prior to methadone being allowed into prisons,

prisoners who were prescribed it in the community were not allowed to continue their script. Thus, on entry to prison, they suffered withdrawals. Introducing methadone was considered to have improved the treatment of drug users on humanitarian grounds. Its presence has shown that the culture of the SPS is changing; there is now an element of caring for prisoners. Some prisoners are aware of this and recognise that the SPS is trying to help them which is constructive for SPS-prisoner relations.

*“It is no longer like what it was. If you came into ***** 15 years ago and you were rattling there were three or four cells in the bottom floor of every hall and they just threw you in there and they just left you for days. Honest opinion is, I suspect it’s been good for the prison service....prisoners are now seeing this as a step we’ve taken to try and help them. They do see it as a positive step.”*

(Staff 003)

A decrease in the amount of drugs in prisons

Several staff reported that they thought that the presence of methadone resulted in fewer drugs in the prisons. A member of staff sarcastically commented on the effect that had on the drug dealers in prison.

“It’s helping people be stable and normal in their daily life. They don’t have to go and chase drugs. The dealers will be well delighted.”

(Staff 010)

However this opinion was not held by all. Some thought that methadone had made no difference to drug availability. The demand for drugs in prison would always exist whether methadone was present or not. Some drug users do not want methadone, some prisoners on methadone still want drugs.

“I don’t think there has been an impact on drug availability at all. None whatsoever.”

(Staff 004)

“Everybody gets hampered with bringing in drugs because drugs means money, money means comfort. To a certain extent methadone might have affected a change here but I cannae quite measure it. I can’t say a lot or even a little.”

(Staff 010)

Problems associated with methadone

Whilst many affects of methadone were positive, it was also described as bringing with it “it’s own set of issues.”

Violence and bullying

Although it was generally reported that methadone had caused a decrease in violence in prison, when prisoners were removed from their script violence often ensued. This could be in the form of self-harm or in destroying SPS property.

Bullying was also an issue in some establishments. Some prisoners were bullied by other inmates not to swallow their methadone, but to hold it in their mouths or regurgitate it, after it had been dispensed to them.

“There are prisoners holding it back, I am sure that is because of some form of bullying. It is not just a case of ‘I will hang on to this and get some money’, they are probably bullied to do that, so it brings problems as well.”

(Staff 014)

Health and safety issues

Health and safety aspects of methadone were mentioned several times. There was widespread concern over inadequate monitoring of methadone and the chances of a prisoner overdosing, there was also concern over the professional integrity of the nurses dispensing methadone in the knowledge that other drugs had probably been taken.

“To hand it over knowing that someone is using on top. I don’t think that should be a nurse’s responsibility.”

(Staff 001)

There was confusion over the occupational hazards of prisoners in work sheds being on regular methadone.

“I think a couple of years ago I remember there being a thing ‘oh can he come to work if he’s taking methadone?’ But can he?”

(Staff 002)

Fitness to work in the sheds was a contentious issue. Prison officers in one establishment were accepting people who were on MMT into ‘drug free sheds’ but not people who were taking cannabis.

“There are tests that are done for medical reasons and not for any other reason and people are starting to get trouble in their work shed or in their environments, because they are smoking cannabis.”

(Staff 005)

Sustaining the effect of PMMT

Despite some problems with PMMT, most staff considered that the benefits outweighed them. They also believed that the beneficial effects of PMMT would disappear if methadone were to be removed.

“The previous state would return [if methadone were to be removed].”

(Staff 009)

“You will get an increase in illicit use. You will go back to where you were, from a discipline point of view.”

(Staff 014)

There was no indication that staff thought that the beneficial effects of methadone would decrease over time. Rather, if some of the problems could be addressed, then the benefits would only increase.

CHAPTER 7. DISCUSSION AND CONCLUSION

The SPS mission is of Custody, Order, Care and Opportunities (COCO). A prison methadone maintenance programme would be encompassed by Care and Opportunities and is thus an integral part of the SPS mission. Such a programme was introduced in 2000 after a change in SPS policy and this study provides insight into prisoners' and staff's attitudes, beliefs, knowledge and behaviour in relation to it. This study fulfils a clause in the SPS Inclusion Policy 2004 which states that service users will have an opportunity to air their views and, where appropriate, influence developments within addictions services at both a local and national level.

The overriding findings are that PMMT is considered by almost all staff and prisoners to have resulted in a considerable decrease in violence and a calmer atmosphere in prison establishments. It has also benefited many prisoners. Along with these positive effects, however, the other most notable theme was that managing MMT in the prison system is presently very problematic and at times it is hazardous and can be open to abuse.

In this discussion section prisoners' perceptions of the effects of methadone and the reasons for wanting PMMT are addressed first before secondly considering the processes involved in managing methadone. Thirdly staff attitudes are then discussed as well as the implications of these for staff training. Fourthly the effects of methadone in prison as perceived by staff will be considered and finally there will be a discussion on the benefits and the limitations of the methodology used in this study before the concluding comments.

Prisoners' perceptions of PMMT

The demand for MMT in the prisons far outweighs the supply at present. The numbers of prisoners on methadone has increased dramatically in the last few years and in some residential halls approximately a quarter of inmates are now on methadone. Thus there is ample opportunity for those not on methadone to see the effect that MMT has on the lives of other prisoners. Indeed, the expectations that prisoners have for their own lives on MMT are usually evidenced by having witnessed these effects in other prisoners' lives.

The positive effects attributed by prisoners to methadone are manifold. Almost all prisoners considered that there was a substantial decrease in violence in the prison as a result of MMT as respondents clearly linked the majority of violence in prison with obtaining a supply of drugs.

The ability of MMT to 'stabilise' a drug user was frequently described. There were many important aspects to a prisoner being stable. There was less stress in life. There were no withdrawals when a drug supply dried up. Having a craving satisfied by a once daily medication could potentially make life in prison very, very different. There was no longer the day long chase for drugs. Debt was no longer mounting as a result of purchasing expensive drugs in prison. Relationships with families were better as the prisoner was no longer solely concerned with drugs and could think beyond them to personal relationships, also the family were no longer being pushed into debt to help maintain their relative's prison drug habit. There was time for reflection and many prisoners became involved in courses, education or recreation in a constructive way, they could now utilise what the SPS had on offer. Many thought, however, that there should be 'drugs courses' that were more suitable for those on methadone. Some went to work, although as discussed later, methadone not dispensed in the morning before work may hinder this. Relationships altered, most prisoners on PMMT would no longer socialise with their drug using friends but developed social circles that would not lead them into drugs, and relationships with some prison staff were reported to improve.

It was acknowledged, on questioning, that there had been a reduction in risk behaviours secondary to PMMT but this was rarely proffered as an effect by prisoners unless they were directly questioned about it. This was more frequently described as an effect by staff.

Why prisoners want PMMT

When prisoners described why they wanted PMMT, all the above factors were mentioned, with more or less emphasis depending on the person, although very rarely would a prisoner mention risk reduction. In general, a better quality of life in prison was sought.

Some prisoners, however, also had longer-term perspectives. PMMT could be integral to successful sentence management. Thus it enabled prisoners to progress through the SPS to more privileged sites. Some wanted it to affect their drug habit; some however wanted it so that they could be seen to be ‘playing the game’. They wanted it to appear as though they were doing something constructive about their drug dependency so they would be looked on favourably at the Parole Board.

A minority of prisoners were thinking very long term that this was a serious attempt to stop drugs and leave the prison free of any habit.

As well as laudable reasons for wanting methadone connected to the good effects it was seen to have in peoples’ lives, there were also prisoners who wanted it as ‘an insurance policy’, to have in case their drug supply dried up. These prisoners may hold their methadone back for themselves at a time when they required it or they might sell it at times. Bullying for methadone also occurred although only in establishments where consumption of methadone was not adequately supervised. These abuses of the system were not well received by prisoners who were genuinely trying to make a difference in their lives. These prisoners were delighted that the SPS were now offering this chance of help in prison and did not want it ‘messed up’ by others.

Why prisoners don’t want PMMT

There were several reasons for not wanting PMMT. Firstly withdrawal from methadone was commonly judged to be far more severe than the equivalent withdrawal experience from heroin. If a drug user’s heroin supply dried up in prison then they felt that they could cope better with withdrawal from heroin than withdrawal from methadone. Such was the fear of withdrawal from methadone that this fact alone often was the single greatest disincentive towards choosing PMMT for drug using prisoners. This fear was compounded by the fact that the SPS were ‘in control’, that is, if the prisoner transgressed, the SPS would stop their script and would not adequately detoxify the prisoner. Control was mentioned in two ways. First, prisoners believed that once they were on a methadone maintenance prescription in prison, the authorities had unacceptable, potential leverage over their daily activities because they controlled the drug that alleviated daily withdrawal pains. The

second “control” issue was the perception that methadone itself would exert too much control over the individual’s functioning in the long run.

Another prominent reason for not wanting PMMT was that some individuals preferred to pursue illicit drugs in prison. Heroin’s qualities made it a proven commodity for prisoners seeking to ‘escape’ daily prison life and the stress of what they had left behind in the community; methadone did not produce such a feeling. Also, the time spent chasing drugs was described by many as something that helped to pass the time and get them through their sentence. They would be at a loss for something to do should they not be chasing drugs.

Other deterrents from starting methadone were confusion over assessment and work-up procedures, disagreements with addiction staff who were gatekeepers to PMMT and the belief that marking themselves out as a drug user might result in more punishments than benefits in the present system.

The final reason why prisoners did not want PMMT was that some preferred to use methods other than methadone to move away from a drug taking lifestyle whilst incarcerated. Occasionally this involved the use of will power but more usually other medications such as buprenorphine were mentioned.

Those who maintained a determined stance against PMMT were rare. Much more common were those whose attitudes towards wanting and not wanting PMMT were flexible and many more reported having revised previously held entrenched positions. Of note, side effects from the drug itself were not cited as a reason to disregard the possibility of methadone treatment.

Process of PMMT

Starting PMMT

Consideration of the above factors, and the subsequent decision that they would like to try PMMT, was often the easiest part of a long process for prisoners that only sometimes resulted in them starting PMMT.

There was much confusion amongst prisoners in all establishments and in all prisoner groups as to the selection process to start methadone. Many prisoners had been trying

to get on PMMT for a long time but did not understand what was actually required of them to receive PMMT or why they had to wait for it.

In all establishments, some prisoners seemed to be inexplicably fast tracked onto methadone in a matter of days, others had to go through lengthy assessments, and others seemed just not to be asked to come forward for an assessment at all.

The most commonly cited criteria for prioritisation in all establishments were behaviours that could result in BBV spread such as injecting drugs and sharing needles. However, suggestions of 'how to get on MMT' varied greatly between different prisoners. Some thought being vociferous about a request or threatening violence may be effective, others thought that being seen to 'toe the line' and not abuse any other help on offer might aid the cause, still others thought that befriending a member of the team helped. Some prisoners even sought solicitors' involvement in the process. In some establishments providing negative urine samples was required in other establishments it was positive samples that were required.

Among prisoners there was a general great lack of understanding of the decision process. Indeed one prisoner, who could clearly not see any structure to the process, put it down to 'there just being favourite cons'. Some prisoners had become quite disillusioned and had given up hope of ever getting methadone.

This great confusion was attributable to a number of different factors.

(1) The methadone system in prison is still evolving, thus changes to protocols are not infrequently made within establishments. This reveals itself, for example, in the view that long-term prisoners may be prioritised against short-term prisoners whereas in mixed establishments historically, the opposite was the case.

(2) There are overt differences in different establishments, for example the requirement to produce positive urine samples in some establishments and the requirement to produce negative urine samples in other establishments.

The requirement to have to produce two positive samples requires consideration because for several reasons it may not constitute optimal practise. Firstly, in the present system, prisoners can readily falsify results. Also, at times, establishments do

run low on drugs and a prisoner may genuinely not be able to produce a positive sample as a result of an inability to find drugs. Thirdly, the requirement for positive samples may also encourage more drug use and fourthly, inherent contradictions also come into play. Such contradictions were reported as preventing prisoners presenting themselves for treatment because the prisoner, in producing two positive samples, has marked himself out as a drug user and may thus suffer many punitive actions without the guarantee that he will be commenced on MMT. This is discussed more fully, later.

The requirement for a drug user seeking help with his addiction to produce negative samples before being further assessed was anathema to all but a few addiction staff. A lot of prisoners were repeatedly asked to produce clean urines before going on MMT. The ability to provide clean urine samples was supposedly a demonstration of their commitment to stop taking drugs and therefore their suitability for methadone maintenance treatment. These prisoners found themselves asking for help with a drug problem but were told they could not receive help unless they stayed away from drugs. Some prisoners even found themselves downgraded in residential hall whilst this was going on. The requirement in some establishments to produce urine samples that are drug free before a methadone script is issued should be reconsidered.

(3) Across the different establishments there were a wide variety of assessment practices and work-ups prior to a prisoner being put on a methadone script. In general there appeared to be fast and slower track assessments. Fast track occurred as a result of a prisoner being a very chaotic drug user or high BBV risk and they are moved rapidly through the system with the understanding that more work can be done with them once they are stable. In some establishments some prisoners are fast-tracked for MMT as a result of being put forward by those in authority. There were numerous instances cited when, in certain establishments, individual prisoners were very much 'pushed' into being considered for methadone, if not actually 'pushed onto a script'. That these prisoners were described as drug dealers or very disruptive prisoners brings into question the motive behind these occurrences.

Recommending prisoners for methadone is contentious. Some prisoners may end up benefiting and needed the push from the authorities to take the step into taking methadone. One could then argue that although the prisoner had not come forward himself to ask for treatment that recommending him for treatment was not an abuse of

power but rather a helpful referral. However, if the behaviour of individuals is the focus for intervention then the situation could be seen as one of abusing control. It could also be an abuse of power if the prisoner is not himself much interested in MMT, at which point it could be disadvantageous to the prisoner to become addicted to another substance without being interested to try and achieve the benefits from it. It also becomes an abuse of control if an individual prevents other equally needy individuals from having MMT because their behaviour does not present a problem to the SPS. Governors or others in authority should not be able to interfere with the addiction team's professional decision process concerning who goes on MMT.

Longer assessment processes were stated to be primarily for gauging a prisoner's motivation to receive MMT. However many thought that 'playing for time' and accessing drug-intelligence from prisoners were the main reasons for the existence of this process. Prisoners reported the swapping of intelligence on drugs for a fast track assessment or for more lenient treatment after drug testing. Collecting intelligence in return for 'favours' and more lenient treatment is clearly not acceptable behaviour.

(4) There is little consistency across different establishments with respect to capping the numbers on MMT. Policies on capping numbers were problematic and resulted in great disparity in who is given methadone and who is not. As there is frequent prisoner transfer between different establishments, policies in these different establishments should be similar. Also if there is a cap on numbers and a prisoner comes in from the community on a methadone script then he is effectively prioritised over someone waiting in prison to start methadone. Some prisoners may not present themselves for treatment because they consider that there is 'no hope' of ever getting methadone. Delay in commencing treatment in the community is reported as causing increased drug-related harm to the drug user (Forman, 2001). It is important to note that prisoners waiting endlessly for treatment may become more entrenched in a drug-pursuing lifestyle in prison with its inherent risk of blood borne virus transmission and spiralling debt.

(5) Different doctors dealt differently with similar clinical situations. Ultimately, there are protocols that can act as a framework around which to make clinical decisions. However, clinical decisions must be based on assessment of each individual's

complex situation. Thus it is not possible to treat all cases identically and this clinical concept is not readily conveyed to prisoners.

Basic protocols (around which clinical acumen is required) for decision making should be transparent to the prisoner. If a prisoner is waiting for methadone or being refused methadone then an explanation of why that is the case should be given to him.

Monitoring

Prisoners on MMT were subject to physical monitoring for methadone and other drugs and, to a lesser extent, but not unimportantly, psychological monitoring.

Across the establishments the monitoring of those on methadone was very haphazard. Testing frequency was very variable and in only one establishment was a fixed monitoring structure commented on. In another establishment a system was described which treated every prisoner independently with respect to frequency of testing.

In all establishments, however, different members of staff in the same establishment did not concur on what their monitoring practice was. Medical staff tended to be more positive and described more frequent testing and more adequate methods and were more confident of the test results.

An AXA machine was available in some of the establishments to accurately determine which drugs and at what level they are present in the prisoner's urine. However, this machine's accuracy depends on the sample tested not being falsified.

There was general acceptance of the readiness with which test results could be falsified and, as a result, prisoners and staff alike often placed little confidence on the results. Voluntary testing, which required a sample to be handed in at a desired time, was most open to abuse as it was easy to simply hand in another prisoner's urine in a sample bottle. Voluntary testing was generally considered to be a waste of time by many prisoners and staff. MDT testing requires that the prisoner is strip-searched and watched micturating. These procedures would prevent the use of bottles of urine from other prisoners that are secreted about a prisoner's person and pricked when required to release urine. However, most reports indicate that prisoners are only sometimes observed passing urine. They should be observed every time and this would result in

confidence being able to be placed on the results produced. If prisoners could have direct access to their results it might build greater trust in the system.

Testing can be used as surveillance or to inform clinical decisions or as a route to punishment. Sub standard 'waste of time' monitoring causes several problems. There is a waste of resources if test results cannot be believed, and no reliable information upon which to make clinical decisions. There is a worrying health and safety deficit in handing medication to prisoners with no confidence that they are not overdosing. It also causes demoralisation among staff who observe prisoners abusing the system and getting away with it and, finally, the surveillance of drug use in the prisons will be incorrect.

The ethos of monitoring or testing was noted as very much for punishment. As such, if a prisoner was having difficulty stabilising and had used other drugs as well as their methadone script then there was no incentive for him to do other than try and falsify a drug test. This situation needs to be rectified if prisoners are to be constructively dealt with.

A lack of psychological support for prisoners on MMT was also commented on from many different sources. Long lists of requests for psychological support transferred into a several weeks or even months wait. In one establishment it was frequently reported that there was only psychological support for those who had started MMT in that prison. There are many changes for a person coming into prison and it may not be assumed that because someone was stable on MMT in the community then they will be stable inside. Lack of needed support could result in the use of drugs on top of methadone and a negative spiral for the prisoner despite 'flagging-up' that support was needed. Residential officers are a largely untapped resource and could be used more to provide accurate information about prisoners' drug related behaviour and urgent need for support.

Inherent contradictions were found in all establishments and generally did not relate to one prisoner type more than another. The most glaring were the punitive effects of testing positive for drugs. There are a profuse number of punishments, affecting many aspects of prison life that could follow if positive drug tests were recorded in a prisoner's file. For example, visit frequency could be reduced, father and child

bonding visits could be stopped, recreation and work shed placements could be affected and sentence progression or parole would not occur.

As previously mentioned, this inherent contradiction resulted in prisoners not coming forward for methadone if they perceived that the punishments might outweigh the benefits of methadone. It also caused reluctance for the prisoners to be honest with staff for fear of chastisement and script removal. The fact that being honest on the part of a prisoner can lead to punishment also reaches into the classical doctor-patient relationship and confounds it. The doctor is the one who prescribes methadone, therefore the wages of their honesty may be script removal.

As it presently stands, due to punishments associated with testing results, there is no incentive for honesty either verbally in discussion or in testing. If using other drugs on top of methadone led initially to further consideration of support rather than to punishment, then prisoners would be less likely to falsify tests and be more likely to be honest with staff. The ethos of testing should not be one of punishment, but one that informs care decisions. Substance testing should be under the appropriate area of healthcare and clinical tests should be kept separately from other prisoner records so that no disadvantage can occur from the results of testing prisoners on MMT. If this change in ethos was combined with a strict procedure at testing then the results of testing would also be far more credible

In some cases, the very presence of testing did have the effect of acting as a deterrent to topping up on a script, in case a positive test would result in the prisoner having their methadone stopped.

Almost all staff acknowledged the great inadequacies and inherent danger of the present situation. Staff positively disposed to methadone commented that MMT could be of great benefit, with the caveat that it needs to be managed properly. Prison officers were often initially reluctant when questioned if more prisoners should be on methadone. However, when questioned about the impact an increase in funds to support an increase in monitoring would make, then support for attending to the waiting list and getting those requiring methadone started on it as soon as possible, often followed.

Staff were confident that they knew what a good level of monitoring would require, but lacked the resources to achieve it. Adequate monitoring (testing and psychological support) would require a lot more financial input.

The prison service is addressing the current state of monitoring. It is proposed that Addictions Prevalence Testing (APT) will be used to identify incidence and prevalence rates and to assist in programme effectiveness evaluation. It is proposed that the mandatory element of testing will be removed as well as the punitive element associated with drug tests, and voluntary testing will occur as part of an individual care plan. APT should see the SPS develop further a philosophy that is supportive and treatment based in relation to addictions. Fundamental to this is the abolition of the inherent contradictions described above.

Non-voluntary reduction

Non-voluntary reduction, or the forced removal of a prisoner from MMT, inevitably follows testing positive for drugs. The problems around such a punitive approach have been discussed above. MMT could be stopped on admission to prison if other drugs were found in a prisoner's urine. There was almost unanimous decriing of this practice from prisoners and staff who were pro methadone because, inevitably, at such a very difficult time as coming into prison, removal of a methadone script resulted in immediate resumption of heroin consumption. Indeed this was the usual response in all but a few prisoners who had their methadone stopped at any point in their sentence. There was also problematic behaviour and a resumption of all the negative aspects of a life of chasing drugs in prison. Of note, no support was given to a prisoner whose script was removed and the detoxification programmes were considered inadequate.

Prisoners did not think that other prisoners should be allowed to abuse the system but simply supported trying to help a prisoner first. A positive test should be used as an opportunity to help the prisoner and then if the abuse continued a removal from their script should be considered, in the line of 'three strikes and you are out' as long as there has been adequate support between times.

There was as little clarity about who was removed from MMT and why as there was about who started it. Generally there were rules in all establishments that a prisoner

was not allowed to take other drugs as well as be on MMT, a contract was signed (if it was not signed the prisoner was not allowed to start MMT) to agree that MMT could be stopped if other drugs were also used. However many prisoners did not really know how strictly this applied to them as they had witnessed a number of different practices for similar transgressions. No consistent practice was reported. Getting a drug using prisoner 'stable' on MMT is not an easy process and the process of removing a prisoner from a script for using other drugs needs to be reviewed. Many benefits accrue from being on MMT, most of which are not dependent on complete abstinence from other drugs. 'Success' of community MMT is measured by significant reductions in use of other drugs, better relations with family, and better possibility of working and or going to classes all of which are perceived effects of MMT in prisons (Ward et al, 1998; Abdul-Quader et al, 1987; Schoenbaum et al, 1989; Farrell et al, 1994; Hutchinson et al, 2000).

Staff attitudes and behaviours

It is clear from data analysis that prison staff have strong opinions concerning the SPS prison methadone programme. Staff's views and prisoners' views on staff completely concurred.

Attitudes in staff from one prison establishment did not vary in any obvious way from those in another establishment. Similar attitudes and beliefs were found in short-term, long-term and female prisons. However, different categories of staff across the different establishments did vary in their perceptions. Addiction staff were more positively predisposed toward methadone than prison officers. Officers, themselves, did vary in their perceptions and tended to fall into one of three attitude groups.

Firstly, many officers have a fundamental dislike of drug users and, in many, this extended to those on methadone treatment. A similar characteristic was also found in some community drug workers (Bell, 1992; Debevec-Svigelj, 1999). A difference here is that prison officers are not specifically trained to work with drug users, rather it is an aspect of their occupation that is present but not overtly stated in their job description.

These officers resented the intrusion of methadone into their daily routine, they resented tax payers' money going to try and help 'junkies' who just abused the help

offered, thought that it was just a free “charge” for the drug users and that they used it as a way of getting out of going to work. These officers often considered that was it the drug users’ own fault that they were addicted. They had a perspective that opiate addiction can be treated as an acute disorder, by letting drug users go through withdrawals until they become ‘clean’. Yet this approach fails to recognise that it is not consistent with achieving long-term abstinence. The wider social perspectives are ignored. Similar grouped beliefs were found elsewhere (McMillan and Lapham, 2005).

Negative attitudes about drug users made staff almost unable to see any positive aspects of methadone. Negative officers tended to focus on the prisoners who were abusing the system rather than on the ones for whom it was helping; negative attitudes towards MMT appeared to be related to negative judgements about the prisoner that the programme served. Thus, staff views were not held in isolation from prisoners’ behaviour.

Such negative attitudes appeared to lead to undesirable behaviours in staff. Staff were repeatedly reported as trying to find ways to have individuals they considered as undeserving, taken off their methadone scripts or else staff would be gleeful when this occurred. Lack of care about dispensing times was also repeatedly mentioned. In a prison routine everything is run by the clock and prisoners become used to that way of life and thus in this environment not receiving their methadone on time is more difficult for them to deal with. There are also possible physiological reasons why receiving methadone at the same time each day would be beneficial.

A different set of staff attitudes was found in the group of officers who had compassion for drug users and saw that methadone could offer some help to them. These officers were pro methadone, but generally sought better support and monitoring improvements to the programme. There are a significant number of officers with compassion for drug users. Why all staff do not feel this way was not entirely clear. It may be down to personal characteristics, but what came across was that the staff that supported methadone the most were also most knowledgeable about it. Whether this knowledge pre or post dated a positive attitude is not known except in the case of some residential officers who had become addictions officers because they had developed an interest in the subject and wished to know more and hence swapped

jobs. During many opportunistic conversations with officers not formally participating in the study it appeared that officers with compassion for drug users and those on methadone, tended to be older officers rather than younger. This was found elsewhere (McMillan and Lapham, 2005). However prisoner reports on this were mixed; some thought that older staff were more confrontational and antagonistic, others thought that younger officers were more likely to have these characteristics. Studies in the community (Magura, 1997) have also reported this latter view.

Somewhere in the middle of these two positions were officers who were happy to go along with methadone, not from the prisoners' perspective but rather their own. Their jobs were made easier by putting 'junkies on methadone'. This group of officers, however, could cause problems by virtue of a lack of protocol for drug users on methadone. It may be that the optimal position is to not to have strict protocols to be adhered to and that each prisoner's status concerning methadone is considered independently. However, from discussion at interviews, the impression was gained in several establishments that the prison officers were almost 'running the show' concerning who would be taken off their methadone or who had to be put back on it. Thus they could choose whether or not to report a prisoner for topping up or insist that their behaviour was so bad in the residential hall that the health centre should just give the prisoner one last warning before having their methadone removed. These officers tended to make decisions about methadone depending on how it suited into their daily activities or otherwise. The fact that the officers in some establishments were in this position could be attributed to a lack of lead from the addiction team, in particular the medical staff.

Perceptions of methadone's effects were influenced not only by underlying attitudes but also by exposure to methadone. Different staff groups had different types of exposure to methadone in the prison. Operational officers, for example, had an increased workload because there was more prisoner movement. Residential officers lived with the daily abuse of methadone under their noses, as well as its quietening effects. Also significant was the amount of education that staff had had about methadone. Apart from staff who were so negative about MMT that 'they did not wish to waste their time' considering it, almost all staff expressed a desire for more training about methadone.

Staff training

In 2000 the SPS changed their policy and allowed MMT to be started in prison establishments as well as continued in those who had come into prison on a methadone prescription from the community. However, despite this change in policy and the probable subsequent effects of it, there was no training of prison staff about methadone. When asked how they were told that methadone was to be introduced into the prison, for the majority it was simply that; they were merely told. The change in policy was brought in haphazardly across different establishments. Staff were informed that methadone was to commence and no further guidance was given.

As a result, staff developed their own conceptions or misconceptions concerning methadone. In 2000 there were a handful of prisoners in SPS establishments on MMT, by July 2003 there were 587 inmates receiving methadone and by June 2005 there were 886. Administration of methadone to this ever-increasing number of prisoners has had a huge effect on prison life.

The researchers were surprised by the delight from prison staff that this research was being conducted. It was evident that many staff felt very put upon by the SPS, and were trying to do their best under burgeoning numbers of prisoners on methadone. Staff appeared relieved that someone wanted to hear their thoughts on the matter.

Some staff had reacted positively to methadone and could see its benefits; others had reacted very negatively and greatly resented the intrusion of methadone into their lives. It may be that some staff would always have become anti-methadone. However, if an education campaign had been conducted on the subject of methadone, then many staff may have understood treatment aims and policies and may not have come to resent the methadone treatment programme to such an extent. In some respects, unrealistic expectations of methadone through lack of education on the matter has served to increase the animosity to drug users and those on methadone and perpetuated a negative circle.

Considering the impact that the change of policy had on the lives of their staff this lack of education and training was clearly an omission by the SPS. The level of training that staff had about methadone affected their expectations, and expectations

of treatment were crucial to staffs' perceptions of benefit from methadone. Staff with more education about treatment with MMT in a prison were more able to appreciate its complexities. Addictions workers, medical staff and governors were far more enlightened about methadone, and of what the SPS' expectations of it might be, whereas prison officers were rarely so. Among some prison officers there appeared to be a reluctance to acknowledge the benefit of MMT unless prisoners ended up off methadone. The idea of continuing on this drug, as people may do other medications, was unacceptable to them. The Advisory Council on the Misuse of Drugs and guidelines from the Department of Health describe the hierarchy of needs following a natural progression from chaotic drug use to abstinence. Prison staff and the MMT programme may benefit if staff appreciated these needs. Many staff, other than those who worked in the addictions unit, tended to award methadone merit or otherwise depending on either how it affected them in their job or on their attitude to drug users.

It has been repeatedly stated that the success of MMT programmes in the community (Bell, 2000; George, 2000) and in prison (Neale, 2004) rely on good staff attitudes and good staff-client interaction. The prison MMT programme will be implemented in the SPS regardless of the wishes of some of the prison staff. But logistical barriers may be introduced by resistant staff. The success of the prison MMT programme and the well being of a prison might be improved by getting 'on board' the resistant staff members.

Staff often bemoaned their lack of training. In their work using psychometric testing of attitudes in prison officers against their knowledge, in a jail in the US, McMillan and Lapham (2005) report that a positive attitude, which they found to be directly influenced by knowledge of MMT, is most strongly associated with readiness to accept a MMT programme in the jail; it also enhanced effectiveness of jail programmes.

Education about MMT could bring increased job satisfaction, as the time spent on managing methadone might be considered more worthwhile.

Staff perceptions of the effects of methadone

The effects of methadone, as perceived by staff, reached into many aspects of prison life. Its effects on the whole prison system were overwhelmingly described as one of

increasing calm. Fundamentally, as reported by prisoners, staff also thought that there was less violence in the prison as there were fewer fights caused by disagreements over drugs. Even in the female prisons, where there was previously a less violent atmosphere, methadone was still described to have a ‘settling’ effect. This is an affect of methadone that is not described in the community literature. Recidivism is variously mentioned but the crimes are often stated as being that of an acquisitive nature rather than a violent one (Peters et al, 1998) (Gossop et al, 2000).

In a culture that has quantitative targets the fact that MDT figures have been noted to drop as the number of prisoners on methadone increase also stands in methadone treatment’s favour. Reductions were also noted in suicide rates and in demand for appointments at the clinics in the Health Centres. It is not possible however, to attribute these findings solely to methadone, although many staff believed that to be the case, nor is it possible to know of a parallel effect in the community.

Almost all staff agreed that, in the majority of individual prisoners, MMT achieved a stabilising effect, and, as discussed, it was these effects that caused the majority of prisoners to want MMT. Some staff considered that this effect was only worthwhile if this stability extended to liberation and the prisoner, when back in the community, did not return to drugs and crime. The number of individuals who fell into this category was reported to be small. Others considered that even achieving stability in prison was a goal worth pursuing.

Methadone was originally introduced into the prison system to reduce the risk of blood borne infection and most of the staff interviewed thought that it was effective for this purpose. In the light of the evidence for increased prevalence of blood borne viruses in prison (Taylor et al, 1995) and known intra-prison transmission of viruses (Stark 1997; Buavirat 2003; Champion et al, 2004) then this would appear to be an important benefit. Twenty-six thousand people move in and out of Scottish prisons each year. Failure to address harm reduction adequately in prison can have a marked impact on the health of the general public as prisons can be seen as ‘breeding grounds for BBV infection’ to be taken back out into the community.

The many descriptions by staff of the transformations of individual prisoners’ lives after they had been commenced on a methadone script were very affirming and

mirrored the descriptions given by prisoners. MMT had the ability to take away the craving for drugs, to cease the relentless search for heroin and to stop the chaos that ensued under these circumstances. Prisoners found themselves able to engage in other long-neglected areas of their lives. This stabilising effect was repeatedly seen as being very beneficial to their family. Interestingly, the ability to affect family life positively is one of the main criteria that the National Alliance for Methadone Advocates (NAMA) states should be considered when assessing the effectiveness of methadone treatment in an individual's life. The affect appeared to be direct in that the prisoner, rescued from a drug-centred world can have time for his family and, indirectly, in that the family also benefits by no longer incurring debt from drugs consumed by their family member in prison. Clearly there is also a decrease of drug debt for the individual prisoner as well. This may be a factor in decreasing recidivism, as on liberation from prison there may be less temptation to enter into crime to pay off debts incurred whilst incarcerated.

The effect of methadone on attendance at work in prison was difficult to assess. Very polarised and opposing views were given. Some considered that inmates on methadone were much more likely to attend their work, other staff, not surprisingly those antagonistic to methadone users, described an opposite effect where being on a methadone script was used as an excuse not to work. A more quantitative survey of prisoners attending work would be required to clarify this issue.

A calmer atmosphere in the prison may not be entirely attributable to methadone because other changes occurred in the prison service around the same time. Principally there was a change of policy and culture leading to more caring key worker roles for residential officers. Previously their role was only custodial; now the residential officers were also personal officers and as such should try to forge relationships with the prisoners.

The difficulties in managing methadone maintenance treatment were much more deliberated by staff. Similarly to prisoners there was concern over MMT eligibility criteria, who should receive a script, who should be removed from it and for what offence. However great attention was also given to the logistics of dispensing methadone and there was concern over monitoring of inmates on methadone and the

possible abuse of the systems. Health and safety issues such as which work parties prisoners on methadone should belong to were also a source of concern

Sustaining the effect of PMMT

Staff considered that the beneficial effects of PMMT were reversible. If methadone were to be removed for some reason it was considered that the previous state would return. They gave no indication that they thought the beneficial effects of methadone would decrease over time. Rather, if some of the problems could be addressed, then the benefits would only increase.

Merits and limitations of the methodology

There are several criteria for assessing quality in qualitative research; one of these is the use of triangulation. Triangulation addresses the issue of internal validity by using more than one method of data collection to answer a research question. In this study, the findings with respect to staff attitudes were evidenced by two sets of views: the prisoners' and the staff's. Although production of similar findings merely provides corroboration and the absence of similar findings does not provide grounds for refutation, triangulation was found to be useful in this study. A form of triangulation occurring in the study is the views of prisoners about staff's opinions. These were entirely in keeping with the actual stated views of the staff members. Another form of triangulation was that data collected from focus groups, comprised of the addiction team in each establishment, contained themes that were pertinent during interviews with staff members. Almost without exception themes raised by the focus groups were mirrored by themes generated during individual interviews.

Respondent validation did occur to some extent as conclusions that were being formulated were discussed and 'tested' at each new interview. There was, however, no respondent validation of written reports.

Another key criterion for judging qualitative research is the extent to which the researcher and the research process have shaped the data, including the role of prior assumptions and experience (reflexivity). The nature of the results may partially reflect the impact of the researcher on the participants. The researchers attempted to elicit information in an unbiased manner. However, their beliefs may have affected the nature of the questioning and conversations that developed. Two researchers with different research backgrounds conducted the interviews independently of each other.

Analysis on the interview transcripts showed no major differences in approach, in the way the questions were asked or in the responses given. Almost all the prisoners interviewed had not previously met the researchers. It may be that their responses would have changed if there had been increased social interaction out of the interview setting.

Recruitment of prisoners was time consuming owing to the nature of conducting research in a high security environment. In general there was no problem recruiting the required number of prisoners in any of the establishments. However as the researchers were not permitted by the ethics committee to approach prisoners personally to ask them to participate, it is not known how many actually declined to participate before another inmate's co-operation was sought.

The small number of staff participants in the study is problematic in that it does not allow the consensus behind some of the different statements to be gauged very accurately. The purposive sample aimed to reflect the diversity within the given staff population. However, the staff groups of interest were slightly difficult to access owing to work commitments and shift work and so in some instances only one staff member from an occupational subgroup was interviewed; for example, only two doctors were interviewed. There were time and financial constraints on the numbers of staff that could be interviewed, but as wide a range of different perspectives as possible was incorporated so that the viewpoint of one group would not be over-represented. When interviewing had completed, a saturation of ideas had not been reached on all topics.

To maximise relevance to other applicable settings the research report has included sufficient detail for the reader to judge whether or not the findings might apply to other similar settings. These results may be generalised to other institutions where staff are recruited similarly and drug use in prisons is at a similar level.

CONCLUSION

Many beneficial effects of MMT were noted and agreed on by prisoners and many staff.

For the individual prisoner, the effects described included increased stability in lifestyle, better family relations, less debt, and risk reduction. For the prison as a whole, MDT figures were described as down, as were suicide rates, and medical clinics were reported as less busy. The residential halls were quieter and there was a marked decrease in violence. Less certain was the effect of MMT on prisoners attending work and the effect on the amount of drugs in prisons and recidivism.

Although many effects of methadone were positive, it was also described as bringing with it its own set of issues. It was difficult to manage: logistically, dispensing methadone to many prisoners is difficult; assessment for MMT and subsequent monitoring of those on methadone are areas where there are many problems, many of which are caused by a punitive approach to testing.

There are also problems with abuse of the system by prisoners intending to use other drugs as well as MMT or holding back methadone for selling. Health and safety aspects of MMT also need attention.

The change in SPS policy to allow MMT in prisons was brought in haphazardly with no training for staff on methadone. The presence of ever-increasing number of prisoners on MMT was described by almost all staff to have had a huge impact on prison life. Many staff were ignorant of the 'treatment aims' of methadone and, as a result, were resentful at what they saw as prisoners abusing help. This resentment may be lessened greatly if all present prison staff were educated about methadone and trained to manage its presence in the prison constructively. Training of all new officers in training college about methadone may aid understanding and stop misconceptions developing. Sensitive placements of new recruits alongside staff who could be positive role models might help promote cultural change within the SPS.

In conclusion, the benefits of PMMT are extensive and the evidence is overwhelmingly in support of continued investment.

REFERENCES

Abdul-Quader AS, et al. Methadone maintenance and behaviour by intravenous drug users that can transmit HIV. *Contemporary Drug Problems*, 1987; 14: 425-434.

Anglin MD, McGlothlin WH, Speckart G. The effect of parole on methadone patient behavior. *American Journal of Drug & Alcohol Abuse*, 1981; 8(2):153-170.

Anonymous. Canada: study demonstrates positive effect of methadone treatment. *Canadian HIV/AIDS Policy & Law Review*, 2002; 6(3):15-16.

Arroyo F. A satisfaction survey of opioid-dependent clients at methadone treatment centres in Spain. *Drug & Alcohol Dependence*, 2004; 73(3): 307-313.

Ball JC, Corty E. Basic issues pertaining to the effectiveness of methadone maintenance treatment. In Leukefeld CG, Tims FM. (eds) *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. National Institute on Drug Abuse Research Monograph no. 86. 1988(b); pp178-191.

Barnett PG. The cost-effectiveness of methadone maintenance as a health care intervention. 1999, *Addiction*; 94(4): 479-488.

Bates M, Pemberton DA. The effect of methadone prescribing in a clinic setting on the criminal activity of drug users. *Scottish Medical Journal*, 2001; 41(6): 173-175.

Bell J. Quality improvement for methadone maintenance treatment. *Substance Use & Misuse*, 2000; 35(12-14): 1735-1756.

Brown BS, Bass UF, Gauvey SK, Kozel NJ. Staff and client attitudes toward methadone maintenance. *International Journal of the Addictions*, 1972; 7(2): 247-255.

Buavirat A, Page-Shafer K, van Griensven GJ, Mandel JS, Evans J, Chuaratanaphong J, Chiamwongpat S, Sacks R, Moss A. Risk of prevalent HIV infection associated

with incarceration among injecting drug users in Bangkok, Thailand: case-control study. *BMJ*, 2003; 326(7384):308.

Bullock T. Key findings for the literature on the effectiveness of drug treatment in prison. Chapter 5, Prisoners' drug use and treatment: seven research studies. Home Office Research Report 267; 2003.

Byrne A, Dolan K. Methadone treatment is widely accepted in prisons in New South Wales. *BMJ*, 1998; 316(7146): 1744.

Caplehorn JRM, Hartel DM, Irwig L. Measuring and comparing the attitudes and beliefs of staff working in New York methadone maintenance clinics. *Substance Use & Misuse*, 1997; 32(4): 399-413.

Caplehorn JRM, Irwig L, Saunders JB. Attitudes and beliefs of staff working in methadone maintenance clinics. *Substance Use & Misuse*, 1996; 31(4): 437-452.

Caplehorn JR, Lumley TS, Irwig L. Staff attitudes and retention of patients in methadone maintenance programs. *Drug & Alcohol Dependence*, 1998; 52(1): 57-61.

Champion JK, Taylor A, Hutchinson SJ, Cameron S, McMenemy J, Mitchell A, Goldberg DJ. The incidence of hepatitis C virus infection and associated risk factors among Scottish prisoners: a cohort study. *The American Journal of Epidemiology*, 2004; 159(5): 514-519.

Clarke JG, Stein MD, Hanna L, Sobota M, Rich JD. Active and former injection drug users report of HIV risk behaviors during periods of incarceration. *Substance Abuse*, 2001; 22(4): 209-216.

Crofts N, Hopper JL, Bowden DS, Breschkin AM, Milner R, Locarnini SA. Hepatitis C virus infection among a cohort of Victorian injecting drug users. *Medical Journal of Australia*, 1993; 59(4): 237-41.

Department of Health. Drug Misuse - Guidelines on Clinical Management. London: HMSO; 1999.

Dobkin JF. Changing the course of AIDS in prison. *Infections in Medicine*, 2005; 22(1): 12-15.

Dolan K, Hall W, Wodak A. Methadone maintenance reduces injecting in prison. *BMJ*, 1996(b); 313(7054): 429.

Dolan K, Shearer J, MacDonald M, Mattick RP, Hall W, Wodak AD. A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug & Alcohol Dependence*, 2003; 72(1): 59-65.

Dolan K, Shearer J, White B, et al. Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, incarceration and hepatitis C infection. *Addiction*, 2005; 100(6): 820-829.

Dolan K, Wodak A. An international review of methadone provision in prisons. *Addiction Research*, 1996(a); 4(1): 85-97.

Dolan KA, Wodak AD, Hall WD. Methadone maintenance treatment reduces heroin injection in New South Wales prisons. *Drug Alcohol Review*, 1998; 17(2): 153-158.

Dole VP, Nyswander ME. A medical treatment for Diacetylmorphine (Heroin) addiction, *JAMA*, 1965; 193: 646-650.

EMCDDA. Annual Report on the state of the drugs problem in the European Union and Norway. 2002.

Erickson PG. Introduction: The three phases of harm reduction. An examination of emerging concepts, methodologies, and critiques. *Substance Use & Misuse*, 1999; 34(1): 1-7.

Farrell M, et al. Methadone maintenance in opiate dependence: a review. *BMJ*, 1994; 309: 997-1001.

Fiscella K, Moore A, Engerman J, Meldrum S. Jail management of arrestees/inmates enrolled in community methadone maintenance programs. *Journal of Urban Health*, 2004; 81(4): 645-654.

Forman RF, Bovasso G, Woody G. Staff beliefs about addiction treatment. *Journal of Substance Abuse Treatment*, 2001; 21(1): 1-9.

George W, Simpson D, Dansereau DF, Rowan-Szal G. Relationships between counselling rapport and drug abuse treatment outcomes. *Psychiatric Services*, 2001; 52(9): 1223-1229.

Gore SM, Bird AG, Cameron SO, Hutchinson SJ, Burns SM, Goldberg DJ. Prevalence of hepatitis C in prisons: WASH-C surveillance linked to self-reported risk behaviours. *Quarterly Journal of Medicine*, 1999; 92(1): 25-32.

Gore SM, Seaman S. Drug use in prison. Methadone maintenance in prison needs to be evaluated. *BMJ*, 1996; 313: 429.

Gorta A. Monitoring the NSW (New South Wales) prison methadone program: a review of research 1986-1991. *Drug & Alcohol Review*, 2003; 22(1): 27-34.

Gossop M, Marsden J, Stewart D, Rolfe A. Patterns of improvement after methadone treatment: 1 year follow-up results from the National Treatment Outcome Research Study (NTORS). *Drug & Alcohol Dependence*, 2000; 60(3): 275-286.

Graff H, Ball JC. The methadone clinic: function and philosophy. *The International Journal of Social Psychiatry*, 1976; 22(2): 140-146.

Graham-Bafus S, Allen RH, Gordon JR. Evaluation of a methadone rehabilitation program. *Psychological Reports*, 1984; 55(1): 99-106.

Gruer L, Macleod J. Interruption of methadone treatment by imprisonment. *BMJ*, 1997; 314(7095):1691.

Haig T. Randomized controlled trial proves effectiveness of methadone maintenance treatment in prison. *Canadian HIV/AIDS Policy & Law Review*, 2003; 8(3): 48.

Hall W, Ward J, Mattick R. Methadone maintenance treatment in prisons: the New South Wales experience. *Psychiatry, Psychology & Law*, 1994; 1(1): 33-44.

Hughes RA. "It's like having half a sugar when you are used to three" - Drug injectors' views and experiences of substitute drug prescribing inside English prison. *International Journal of Drug Policy*, 2000; 10: 455-466.

Hutchinson SJ, Taylor A, Gruer L, Barr C, Mills C, Elliott L, Goldberg DJ, Scott R, Gilchrist G. One-year follow-up of opiate injectors treated with oral methadone in a GP-centred programme. *Addiction*, 2000; 95(7): 1055-1068.

Inciardi JA, Martin SS. Drug abuse treatment in criminal justice settings. *Journal of Drug Issues*, 1993; 23(1): 1-6.

Jeanmonod R, Harding T. The drug addict in prison: medical response and its limitations. [French] *Sozial und Praventivmedizin*, 1988; 3(6): 274-280.

Jones SS, Power R, Dale A. The Patients' Charter: drug users' views on the 'ideal' methadone programme. *Addiction Research*, 1994; 1(4): 323-334.

Kahn, RB. Methadone maintenance treatment: Impact of its politics on staff and patients. *Journal of Psychoactive Drugs*, 1992; 24(3): 281-283.

Kahn RB, Schramm NT, Daoud F. Another alternative - a 90-day contractual detoxification treatment program. *Drug Forum*, 1978-79; 7(1): 51-58.

Keen J, Oliver P, Rowse G, Mathers N. Does methadone maintenance treatment based on the new national guidelines work in a primary care setting? *British Journal of General Practice*, 2003; 53(491): 461-467.

Keen J, Rowse G, Mathers N, Campbell M, Seivewright N. Can methadone maintenance for heroin-dependent patients retained in general practice reduce criminal conviction rates and time spent in prison? *British Journal of General Practice*, 2000; 50(450): 48-9.

Keene J. Drug misuse in prison: views from inside. A qualitative study of prison staff and inmates. *The Howard Journal for Criminal Justice*, 1997; 36(1): 28-41.

Kerr T, Wood E, Betteridge G, Lines R, Jurgens R. Harm reduction in prisons: a 'rights based analysis'. *Critical Public Health*, 2004; 14(4): 345-360.

King CH. Manifest and latent components in methadone maintenance: the methadone maintenance game. *Journal of Drug Education*, 1975; 5(4): 317-326.

Kraus L, Augustin R, Frischer M, Kümmler P, Uhl A, Wiessing L. Estimating prevalence of problem drug use at national level in countries of the European Union and Norway. *Addiction*, 2003; 98(4): 471-485.

Langendam MW, Van Brussel GHA, Coutinho RA, Van Ameijden ESC. Methadone maintenance of injecting drug use: results from the Amsterdam Cohort Study. *Addiction*, 2000; 95(4): 591-600.

Long J, Allwright S, Begley C. Prisoners' view of injecting drug use and harm reduction in Irish prisons. *International Journal of Drug Policy*, 2004; 15(2): 139-149.

McMillan GP, Lapham SC. Staff perspectives on methadone maintenance therapy (MMT) in a large south-western jail. *Addiction Research and Theory*, 2005; 13(1): 53-63.

Magura S, Kang SY, Nwakeze P, Demsky S. Counselor attitudes in methadone maintenance. Society for the Study of Social Problems; 1997.

Mair G, Barton A. Drugs throughcare in a local prison: a process evaluation. *Drugs: Education, Prevention and Policy*, 2001; 8(4): 335–345.

Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. *Addiction*, 1998; 93(4): 515-532.

Martin Sanchez V, Cayla Buqueras JA, Gonzalez Moris ML, Herrero A. Evaluation of the prevalence of HIV infection in prison inmates at the time of their imprisonment during the period 1991-1995. [Spanish] *Revista Espanola de Salud Publica*, 1997; 71(3): 269-280.

Merrill JO, Jackson TR, Schulman BA, Saxon AJ, Awan A, Kapitan S, Carney M, Brumback LC, Donovan D. Methadone medical maintenance in primary care: an implementation evaluation. *Journal of General Internal Medicine*, 2005; 20(4): 344-349.

Michel L, Maguet O. Guidelines for substitution treatments in prison populations. [French] *Encephale*, 31(1): 92-97.

Montague M. Appreciating the user's perspective: listening to the "methadonians". *Substance Use & Misuse*, 2002; 37(4): 565–570.

Neale J. Drug users' views of drug service providers. *Health and Social Care in the Community*, 1998(a); 6(5): 308-317.

Neale J. Drug users' views of prescribed methadone. *Drugs, Education, Prevention and Policy*, 1998(b); 5(1): 33-46.

Neale J, Saville E. Comparing community and prison-based drug treatments. *Drugs: Education, Prevention and Policy*, 2004; 11(3): 1-16.

Peters AD, Reid MM. Methadone treatment in the Scottish context: outcomes of a community-based service for drug users in Lothian. *Drug & Alcohol Dependence*, 1998; 50(1): 47-55.

Rotily M, Weilandt C. Risk behaviour and HIV infection in European prisons. In Moatti J-P, et al. (eds) AIDS in Europe: new challenges for the social sciences. London and New York: Routledge, 2000. Chapter 11, pp149-164.

Schoenbaum EE, et al. Risk factors for Human Immunodeficiency Virus Infection in intravenous drug users. *New England Journal of Medicine*, 1989; 321: 874-879.

Scottish Executive. Updated National Drug Strategy. 2002.

Scottish Prison Service. Guidance on the Management of Prisoners who Misuse Drugs. Edinburgh: SPS; 1994. Annex A; Paragraph 6.1.

Scottish Prison Service. Partnership and Coordination: SPS Action on Drugs - revised guidance on the management of drug misuse in Scotland's prisons. Edinburgh: SPS; 2000.

Scottish Prison Service. Inclusion Policies: Scottish Prison Service Inclusion Policy and Guidance. Edinburgh: SPS; 2004.

Shewan D, Gemmell M, Davies JB. Behavioural change amongst drug injectors in Scottish prisons. *Social Science & Medicine*, 1994; 39(11):1585-6.

Sibbald B. Methadone maintenance expands inside federal prisons. *Canadian Medical Association Journal*, 2002; 167(10): 1154.

Sidwell C, Best D, Strang J. Cost of drug use and criminal involvement before and during methadone treatment. *Journal of Clinical Forensic Medicine*, 1999; 6(4): 224-227.

Simpson S. Maintenance programmes are denied to addicted prisoners in Victoria. *BMJ*, 1999; 318(7186): 811.

Sperner-Unterweger B, Fuchs D, Fleischhacker WW, Hausen A, Miller C, Most J, Reibnegger G, Werner ER, Dierich M, Wachter H, et al. Change in HIV-antibody seroprevalence rates in i.v. drug dependent prisoners. *British Journal of Addiction*, 1991; 86(2): 225-32.

Stark K, Bienzle U, Vonk R, Guggenmoos-Holzmann I. History of syringe sharing in prison and risk of hepatitis B virus, hepatitis C virus, and human immunodeficiency virus infection among injecting drug users in Berlin. *International Journal of Epidemiology*, 1997; 26(6): 1359-66.

Stark K, Muller R, Bienzle U, Guggenmoos-Holzmann I. Methadone maintenance treatment and HIV risk-taking behaviour among injecting drug users in Berlin. *Journal of Epidemiology & Community Health*, 1996; 50(5): 534-537.

Stenbacka M, Leifman A, Romelsjo A. The impact of methadone treatment on registered convictions and arrests in HIV-positive and HIV-negative men and women with one or more treatment periods. *Drug & Alcohol Review*, 2003; 22(1): 27-34.

Stoeber H. Drug substitution treatment and needle exchange programs in German and European prisons. *Journal of Drug Issues*, 2002; 32(2): 573-596.

Stuker PB, et al. Addict descriptions of therapeutic community, multimodality, and methadone maintenance treatment clients and staff. *Journal of Consulting and Clinical Psychology*, 1978; 46(3): 508-517.

Taylor A, Goldberg D, Emslie J, Wrench J, Gruer L, Cameron S, Black J, Davis B, McGregor J, Follett E, Harvey J, Basson J, McGavigan J. Outbreak of HIV infection in a Scottish prison. *BMJ*, 1995; 310: 289-292.

Vegue Gonzalez M, Alvaro Brun E, Garcia Pastor S. Evaluation of methadone program in prison: preliminary results. [Spanish] *Addicciones*, 1998; 10(1); 59-67.

Ward J, Mattick RP, Hall W. (eds) Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic Publishers; 1998.

Watson R, et al. Drug users receive worse care in prison than in the community. *BMJ*, 2001; 323: 654.

White AP. The promise, problems and limitations of methadone: a clinical perspective. *Journal of Clinical Forensic Medicine*, 1994; 1(2): 97-104.

Whitling NJ. New policy on methadone maintenance treatment in prisons established in Alberta. *Canadian HIV/AIDS Policy & Law Review*, 2003; 8(3): 45-47.

Wilcox A. Nursing in prisons: understanding educational needs through a case study approach. *Learning in Health and Social Care*, 2002; 1(4): 180–190.

Woods J. National Alliance of Methadone advocates: the voice of the patient.
www.methadone.org/president/nama_archives.html

World Health Organization. WHO guidelines on HIV and AIDS in prisons. Geneva; 1993.

APPENDICES

APPENDIX 1

CONSENT FORM

Participant Identification Number for this trial:

Title of Project:

A study into the Role of Methadone Maintenance Treatment

Name of Researcher: Dr Jennifer Champion

**Please
initial
box**

1. I confirm that I have read and understand the information sheet dated.....for the above study and have been able to ask questions.
2. I understand that I don't have to take part in the study and that I can stop at any time.
3. I agree to take part in the above study.

Name _____ Date _____ Signature _____

Researcher _____ Date _____ Signature _____

APPENDIX 2

Methadone treatment in prison - research project Information Sheet

You are being invited to take part in a research study. Please read the following information sheet and if there is anything that is not clear to you or you would like further information, please ask the researcher. Thank you.

The study

This study seeks to find out about the role of methadone maintenance (substitution) treatment in the prison. It is designed to identify, describe and understand the effect of methadone maintenance treatment in the prison setting.

Taking part in the Study

Taking part in the study would involve an interview which would take about an hour.

You will be asked questions about yourself and issues around your drug use and the affect they have on your quality of life in prison.

The interview would be recorded purely to allow the researcher to remember all that you have said. Your name would not be attached to the information and the tape would be destroyed when the information from it had been collected.

If you take part in the study you can withdraw at any time you wish. Whether you take part in the study or not will not affect any drug treatment programme that you may be involved with now or in the future in any way.

Who is doing the study?

A specialist in public health, working for Greater Glasgow Health Board (GGHB) which is part of the NHS in Scotland.

Confidentiality

The interviews are entirely confidential. Your name will not be written on the questionnaire. GGHB is registered under the Data protection Act and has an Information Security Policy to safeguard the collection, processing and storage of confidential information.

When will the results be known?

The results of the study will be known by August 2005. The researcher would be pleased to report the main findings of the study to all those who took part.

APPENDIX 3

Interview Schedule

To explore prisoners and staffs view on a variety of issues surrounding methadone in prison.

Why do you think that intravenous drug users (IDUs) decide to start MMT in prison?

What are your perceptions of the process of methadone prescribing in the prison setting?

What affect does MMT have on prisoners' quality of life in prison?

What do you think the impact of methadone is on behaviour including areas such as risk behaviour avoidance, social interactions, relationships and networks?

Do you think that methadone maintenance alters prison dynamics and affects levels of violence or intimidation between prisoners?

Do you think that methadone maintenance treatment motivates drug users to seek help to address social and psychological problems attendant with incarceration?

Why do you think that some drug users may choose not to receive methadone?