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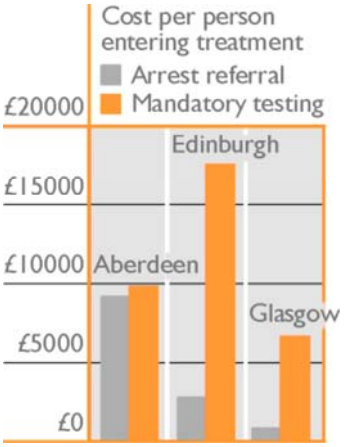
Drug Treatment Matrix cell A5: Interventions; Safeguarding the community

One of 25 cells in the Drug Treatment Matrix

S Lessons of forced treatment in California Civil Addict Program (1977). Study of treatment enforced by the California Civil Addict Program found drug testing and sanctions suppressed crime, but despite a less strict regimen and less resort to residential options, methadone maintenance had a greater and more lasting impact. For discussion click and scroll down to highlighted heading.

S Reassurance of naltrexone blockade opens up reintegration opportunity for heroin-dependent prisoners (1984). Describes what seems to have been the first documented use of naltrexone among offenders, a programme mounted in Nassau County Jail in New York from 1972 which qualified previously excluded prisoners to be let out of prison to work, earn and save money. See also other descriptions of the programme (1 2). For discussion click and scroll down to highlighted heading.

K No crime reduction from mandatory drug testing and assessment of arrestees in England (2018). Schemes which force people arrested for certain offences to be tested for heroin or cocaine use, and if positive to be assessed for treatment, do not pay back in terms of treatment engagement or crime reduction. Evaluation of corresponding policy in Scotland led funding for mandatory testing schemes to be ended but continued for voluntary schemes. In some areas voluntary arrest referral schemes cost six to eight times less per drug user engaging with treatment ▶ chart.

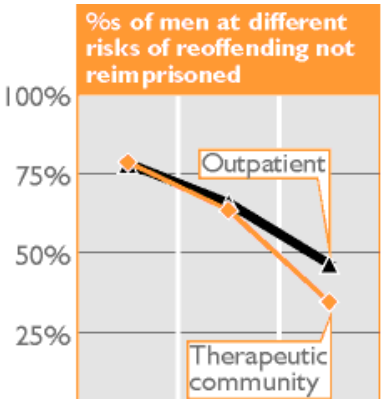


K Flexible drug treatment and testing orders work best (Scottish Executive, 2004). Reconviction rates for drug using offenders in Scotland halved after they started court-ordered testing and treatment programmes; comparison with England suggests more flexible supervision by criminal justice caseworkers helps reduce recidivism.

K Anti-offending programme for drug users did not cut crime (2011). The main cognitive-behavioural group therapy programme (ASRO) for problem substance users on probation in the UK could not be shown to have affected reconviction rates.

K Drug recovery wings face uphill struggle in English prisons (2017). In 2010, drug recovery wings providing a therapeutic regimen for prisoners motivated to overcome drug dependence were an important element in the UK government's turn towards abstinence-based recovery. Improvements in a followed-up minority of prisoners from these wings could not be benchmarked against a comparison group, and physical and mental health declined while on the wings. Patchy therapeutic and recovery-oriented inputs were countered by the anti-recovery effects of imprisonment and lack of support on release.

K No recidivism dividend from prison therapeutic community for high-risk offenders (2014). For the first time in a prison setting a randomised trial rigorously compared intensive residential therapeutic community treatment to outpatient counselling. Confounding expectations, the US prison for problem drug users which hosted the study gained nothing in terms of preventing recidivism by allocating to the more intensive treatment, even among prisoners most likely to reoffend ▶ chart.



K Therapeutic community for paroled dual diagnosis prisoners halves reimprisonment (2012). From the USA, the first randomised trial of a post-prison residential therapeutic community designed for psychologically disturbed problem substance using offenders found it halved the numbers reimprisoned and did even better when preceded by similar in-prison treatment, confirmation that what happens when people leave prison can be

critical.

K Supervised naltrexone works for opiate-dependent offenders (1997). First randomised trial exemplified the conclusion that naltrexone has a role among closely monitored offenders who have much to lose (in this case, their freedom) from dropping out of treatment and returning to opiate use, especially when pill-taking is supervised – but also indicates that given the choice, few opt to have their freedom to use opiates pharmacologically curtailed. For discussion click and scroll down to highlighted heading.

K Randomised trial finds long-acting opiate-blocker reduces opioid use by offenders (2016). Long-acting naltrexone product injected into the body supplemented usual drug counselling for offenders with a history of opioid dependence living in the community under criminal justice supervision. The monthly injections were mainly renewed as intended and while active helped prevent relapse to opioid use but with no lasting effects. For discussion click and scroll down to highlighted heading.

K No demonstrable benefits from intensive support for "troubled families' ([UK] Department for Education, 2011). Evaluation of national payment-by-results scheme to 'turn round' troubled families in England found substantial remission in substance use problems, but could not attribute these to the interventions. Final evaluation report (2016) on the programme as implemented from 2012 to 2015 found that relative to comparison families, there were no significant impacts on substance use or outcomes related to employment, job-seeking, school attendance and anti-social behaviour. From 2015 the programme was revised to target families with a much broader range of disadvantages and to help younger children benefit; findings in relation to a appropriate comparison group have yet to be published.

K Intensive support for substance-using parents enabled children to stay at home (Welsh Assembly Government, 2008). Found that a service which worked intensively over a few weeks with substance-using parents whose children faced imminent care proceedings forestalled their removal from the home. Later study (2012) of the same service confirmed this was not at the expense of the children's welfare. For discussion click and scroll down to highlighted heading.

K Intensive English programme helped keep children at home (2009). Intensive short-term intervention by a specialist service for substance-dependent parents reduced the need to remove their children from the home. For discussion click and scroll down to highlighted heading.

K Therapeutic orientation improves outcomes of child care proceedings in London (2016). First UK family drug and alcohol court achieved lastingly better parental and child outcomes at lower cost ([UK] Home Office, 2012). The authors said "there was a sound basis for comparing outcomes" but the families allocated to the family drug and alcohol court versus usual care proceedings derived from different boroughs and were not randomly assigned. For discussion click and scroll down to highlighted heading.

K Treating couples together further reduces domestic violence (2002). Engaging potentially violent male drug users and their partners in therapy together needs great care (2007) but can reduce domestic violence more effectively than individual treatment. Similar results from this later study (2009) of the same approach from the same lead researcher.

K Support the relatives too (2011). Brief primary care counselling seemed to help relatives in England cope with living with a problem substance user, but without a control group against whom to benchmark the outcomes the study could not be sure the outcomes were due to the interventions.

K Maintain prisoners on methadone rather than imposing withdrawal (2018). From the USA, a rare randomised trial found in favour of continuing methadone maintenance when patients entered prison rather than compulsory withdrawal. The potential benefits were most apparent in the near-100% continuation of protective treatment during the highly overdose-prone weeks after leaving prison.

K Needle exchanges help keep area free of discarded syringes (2012). A major concern about needle exchanges is that after use the injecting equipment they supply will be left unsafely disfiguring public areas, but this US study strongly suggested the opposite.

R European studies find treatment cuts crime (2014). Amalgamated results from European studies which randomly allocated illegal drug users to treatment versus no or usual treatment indicate that treatment (especially opioid substitute prescribing using drugs such as methadone) substantially curbs the criminal activity of the patients. For discussion click and scroll down to highlighted heading.

R Treatment and supervision of drug-dependent offenders (2008). UK-focused review by the Institute for Criminal Policy Research in London: "the strongest evidence seems to favour the use of therapeutic communities, interventions modelled on the drug court approach and substitute treatments such as methadone maintenance."

R Equivocal evidence for coerced treatment of drug using offenders (2013). Notes that "to justify the disempowering nature of coerced treatment, practitioners, policy-makers, and researchers are obliged to demonstrate [its] effectiveness …" Maps the criminal justice process from pre-arrest to post-release, revealing lacking or equivocal evidence for coerced treatment at most stages, and that the strongest record is for offending reductions generated by drug courts – though these have been criticised (2010) for bringing more drug users into the criminal justice system and ultimately punishing the many who do not respond as intended.

R Integrate community-based treatment with criminal justice supervision (2003). Leading US expert makes sense of the literature, extracting the principles underlying effective treatment in the criminal justice system and identifying effective interventions.

R Opioid maintenance treatment works in prisons too (2011). Continuity of methadone maintenance from before to during and after prison is the key to gaining benefits similar to those in seen in community settings.

R Is therapy undermined by a punishment context? (2005). Asks whether in criminal justice settings, the contradictions of helping and punishing at the same time ('motivational arm-twisting') undermine interventions which might work elsewhere – in particular, the client-centred motivational interviewing style of counselling.

R Preventing drug-related disease spread in prisons (2009; free source at time of writing). Findings likely to be applicable to any blood-borne disease are that needle and syringe programmes and opioid substitution treatment have proven effective at reducing HIV risk-behaviours in a wide range of prison environments, without negative consequences for the health of staff or prisoners – important findings because having been in prison has repeatedly been associated with increased risk of infection. See also review of HIV prevention specific to opioid substitution treatment in prison and (among other factors) study attributing the low incidence of hepatitis C infections in Scottish prisons to the widespread in-prison opioid substitution treatment.

R Treatment's impact on the children (2009). Exhaustive search found just a handful of studies relevant to whether treating substance-using parents in the criminal justice system improves their children's welfare.

R Routine substance use treatment can reduce domestic violence (2009; free version at time of writing). When successful, treatment in general results in reduced violence between sexual partners; couples therapy has yet greater impacts, but is not always (2007) safe or feasible. For related discussion click and scroll down to highlighted heading.

R Family programmes can improve prospects of children of problem substance users (2012) Of the reviewed programmes, most effective were those which involved both parents and children, particularly the Strengthening Families Programme (2004). For discussion click and scroll down to highlighted heading.

R Can opiate substitute patients drive safely? (2013). Methadone and buprenorphine certainly can make non-dependent drivers unsafe, but the jury is out on whether driving is impaired among dependent patients maintained on these drugs and who have therefore developed tolerance to their effects. Individual assessments are needed. UK guidance (2017) allows stabilised methadone and buprenorphine patients assessed as safe to drive to do so.

G Clinical management of drug dependence in the adult prison setting ([UK] Department of Health etc, 2006 and 2010 update).

G Treating prisoners in Scotland (Scottish Prison Service, 2011). Official guidance on the commissioning, management and delivery of interventions for substance-misusing offenders, dating from before the transfer of responsibility for treatment in Scottish prisons prison to the NHS.

G Health in prisons (World Health Organization [etc], 2007). Chapters on drug services in general and substitute prescribing in particular.

G US expert consensus on treatment in the criminal justice system ([US] Substance Abuse and Mental Health Services Administration, 2005). Guidance on interventions, matching to the offender, and planning programmes.

MORE Search for all relevant analyses or for subtopics go to the subject search page or hot topics on supporting families, drug testing and sanctions, naltrexone implants and injections, and protecting children.

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What is this cell about? About treatment funded or ordered to safeguard the wider community, or studies of whether treatment in general has a safeguarding impact. Treatment focuses on the welfare of the individual patient, but it may be funded and organised by authorities whose primary motivation is to safeguard the wider community. In these cases treatment is offered or imposed not because the substance user has sought it, but because it is thought that treating their substance use could result in benefits to the community. Typically these take the form of reductions in crime committed in order to fund drug purchases, but also reductions in non-criminal behaviour which the community finds offensive and/or which degrades the local social or physical environment. Treatment not organised primarily for these purposes may nevertheless have these benefits; studies and reviews documenting these effects are also included in this cell. Also here are interventions which focus on the welfare of the children and families of people with drug use problems, rather than seeing the family primarily as a means to promote the welfare of the problem user.

Where should I start? This review of European studies (mostly from the UK) reminds us that offenders do not have to be legally coerced in to treatment to reduce crime; that happens 'naturally' and almost certainly at lower cost in the course of voluntarily sought addiction treatment – an argument for seeing the primary crime reduction tactic not as coerced treatment, but making voluntary routes to treatment as attractive and available as possible.

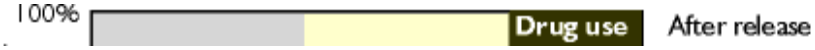
The magnitude of the European crime-reduction dividend was estimated by amalgamating results from all 15 evaluations found by the review. It amounted to a 37% extra reduction in criminal recidivism due to the treatments the studies focused on, relative to the treatments they were compared with. Given the nature of the studies, this is best seen as an indication of the impact of *improving* treatment. Some of the comparison treatments – in particular, methadone maintenance – are themselves powerful crime reducers, so the *total* impact of treatment versus no treatment is likely to be substantially greater. Evidence and impacts were strongest for opioid substitute prescribing programmes, less abundant and less convincing for abstinence-oriented treatment, psychosocial therapy, and therapeutic communities.

As detailed in cell E2's bite, it is hard to overestimate the significance of the crime-reduction dividend in the recent history of drug addiction treatment in Britain. Because it reduces the need (as they would experience it) for overwhelmingly poor and unemployed patients to raise money for illegal drugs, crime-reduction remains the main economic – and perhaps too, social – justification for funding treatment. This is the case not just in Britain, but also across US cost-benefit studies, in which crime usually accounted for most of the cost savings for society from addiction treatment. In contrast, the US review found savings in health service costs and gains due to increased employment were relatively minor. Interestingly, this means the illegality of the drug market (itself the cause of high prices) underpins the economic and social rationale for treatment; what would happen to that rationale if supply was legalised and the market looked more like that for tobacco or alcohol?

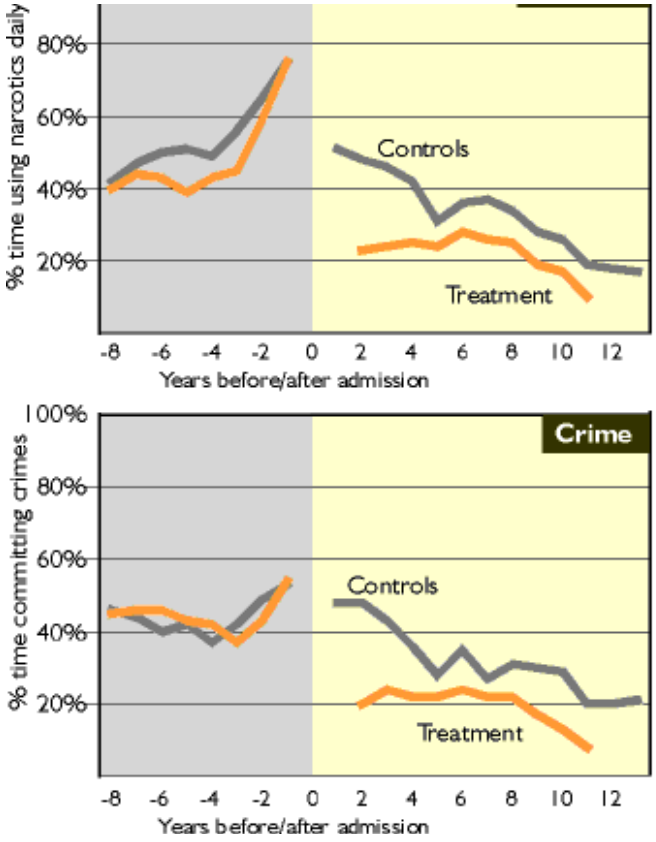
Highlighted study Recognised by British commentators as "some of the best evidence of the benefits of legal coercion" and as "key research" indicating that "those who receive legally coerced treatment respond no worse than others", from the 1970s the study of the California Civil Addict Program remains a uniquely convincing demonstration of the power of directing drug dependent offenders in to treatment bolstered by criminal justice supervision – the model decades later adopted by the UK in the form of Drug Treatment and Testing Orders and carried on as Drug Rehabilitation Requirements.

The study stands out because administrative blunders as the programme was bedding down in the early 1960s created the evaluator's Holy Grail – a near-perfect control group created without having to interfere with the processes being studied. It was formed of addicts who *should* have gone through the programme but had escaped due to the mistakes – effectively a randomly selected set of similar drug users against whom the impact of the programme could be benchmarked.

Our review and analysis of the



component studies explains that though the intention was to sweep up California's addicts whether or not they were offenders, in practice the programme diverted convicted offenders from prison into treatment, making it directly relevant to UK initiatives. Broadly the findings were that compulsory residential treatment led to immediate falls in drug use and crime which the succeeding drug testing and criminal justice supervision helped maintain even when the recipients were back on the streets. Though the gains faded when supervision was withdrawn, the results meant 'Throw them in prison and then throw away the key' now had a viable competitor: coercion with a (rehabilitative) purpose.



from residential rehabilitation, treated addicts spent far less time than controls using narcotics and committing crimes. However, the gaps narrowed over time and when availability of voluntary entry to methadone maintenance helped controls to curb their drug use.

Later a change in the programme to shorter residential treatment and less strict supervision, and the advent of widespread methadone maintenance, enabled the researchers to probe not just whether, but *how* the programme worked. The interpretation of the results was that legal supervision – especially when contact is frequent and bolstered by drug testing and sanctions for detected use – is an effective way to address addiction among addicts processed through the criminal justice system, but typically the benefits do not outlast the supervision and are not as great or as lasting as those achieved by treatments such as methadone maintenance. Integrating the two in an individualised mix offers the best chance of success, argued the researchers: treatment reduces drug use while legal pressure promotes treatment entry, retention and compliance. In this model the legal process serves to reinforce treatment, the reverse of the usual formulation.

Issues to consider and discuss

▸ **Can it ever be safe to leave children with seriously problematic drug users?** Highly charged in normal circumstances, the welfare of children whose parents use illegal drugs became maximally contentious when in 2010 a US project came to Britain offering to pay drug users to be sterilised. Bending to the UK context, the US project reluctantly decided not to pay for sterilisation, but to enable "addicts and alcoholics" to undertake long-term birth control procedures. There are more acceptable and supportive means to the same end, but unacceptable as it was, the project's failed foray highlighted a real problem, potentially affecting about 140,000 children in England living with parents with an opiate use problem. Add in the rest of the UK and users of other drugs, and the figure must be near or above 200,000.

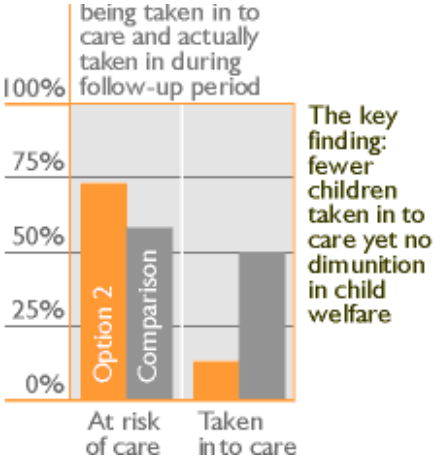
> *Is the risk of relapse and with it the risk to the children simply too great?*

Is it simply too risky to leave their children with the most severely affected of these parents, even if they are in treatment, and even if they appear to have successfully completed it? If substance dependence – and especially heroin dependence – at least *behaves* like a chronic relapsing condition, and even if that is only broadly valid for treatment populations with their typically low de-addiction resources, relapse is to be expected after treatment, and with it, renewed risk to the child. In England in 2016/17, just 7% of opiate-using patients were recorded as having completed treatment and overcome their dependence, while a quarter had returned after previous treatment.

But what if, as well as treatment of dependence, intensive

Families with children at risk of

resources were targeted at strengthening the family and improving parenting – an expert family therapist available 24 hours a day, seven days a week, even if only over four to six weeks? This kind of specialist 'family preservation' service has been tried and evaluated in Wales (listed above) and in Middlesbrough (listed above). Independent researchers found the services prevented the need to permanently place children in care, and reduced time spent in temporary placements. Crucially, over a follow-up period averaging five to six years, one of the Welsh studies listed above was able directly to confirm that reduced resort to care had not been at the expense of the children's welfare; there was no indication that the service had inadvertently harmed children by helping keep them with their families ▸ chart.



The results were convincing enough for the Welsh government to roll out similar services across Wales, initially concentrating on families where there is parental substance misuse and concern over child welfare. Regulations stipulate that teams providing the services must consist of at least five professionals including a social worker, nurse and health visitor, perhaps an attempt to address the need to maintain quality highlighted by researchers. An evaluation concluded that at three first-phase sites, the new schemes "appeared to improve short-term outcomes for a good number of families", though, staff felt, less so for a few with "very chaotic lives and serious multiple issues". There was evidence directly from the families that their lives and those of the children had improved, but with no comparison group, it is unclear whether the interventions were the cause of the improvements.

Do you find the results to date *that* convincing? Remember that the parents in the initial trials were not dabblers in drink or drugs, but had problems serious enough to take them to the brink of losing care of their children. Is the risk of relapse to dependent substance use and with it the risk to the children simply too great? Or is the greater risk to unnecessarily blight children's lives by taking them in to care? Of course, these decisions must be made case-by-case, but still on the basis of an understanding of the general and likely balance of risk and benefit. To help you work through the issues and for more background, read our hot topic on protecting the children of problem substance users.

An alternative is to get the family courts involved (what the family preservation services try to make unnecessary, saving costs), but to use the court's powers to collaboratively arrange intensive treatment and support from a specialist team allied with the court, and to judicially monitor parents' progress while the children are under the care of court-appointed guardians. Like drug courts generally, these 'family drug and alcohol courts' back the treatment process with the leverage available to the court. They also provide immediate, legally-backed safeguards for the children. On the evidence listed above from the UK, they seem to have greater success than usual care proceedings in achieving long-term family stability whilst keeping more children with their parents.

As with crime reduction, it is worth finishing this section with a reminder that in itself, successfully treating substance use problems is likely to improve (listed above) child welfare because it reduces at least some manifestations of conflict and violence in the family and makes competent parenting more possible. Treatment services can and have gone further, offering specific parenting and family support, potentially forestalling the need for the more intensive services discussed above intended to help families already at the brink of losing care of their children. Before that point there seems a strong case for making parenting and child welfare support available to all problem substance using parents in treatment. Because such support is not predicated on the parent admitting to shortcomings in their child's upbringing and welfare (which many will be reluctant to do) or this being discovered, these programmes can reach families in need of help who would otherwise be missed or feel stigmatised and can reduce the numbers who reach the point reached by the families referred to intensive family rescue services. Examples are given in our hot topic on protecting children, and researchers based in the UK who specialise in substance misuse in families have offered recommendations for addiction treatment services based on a review of the international literature.

Are we missing a trick with naltrexone? Or more specifically, are we missing a trick by not pressuring opioid-dependent offenders under supervision to take or be implanted/injected with naltrexone? That questions is addressed at greater length in an Effectiveness Bank hot topic, to which readers who want the full story could turn instead before they return here to answer the questions at the end.

Particularly for offenders, naltrexone seems the perfect medication for promoting abstinence from heroin and allied drugs – a pill taken daily or just twice a week which makes heroin use a disappointment rather than a 'high'. Free itself of psychoactive effects, naltrexone commandeers and blocks the neural receptors targeted by opiate-type ('opioid') drugs. A chemical instead of a physical shackle, it seems in tune with the deprivation of liberty imposed on offenders. At its most optimistic, the hope and expectation is that long-acting naltrexone implants will result in patients "learning to abstain successfully" in the longer term. However, lasting effects are not necessarily critical to treatment linked to a probation or parole order. Judges just need to be persuaded that treatment is likely to prevent or keep offending to a minimum for as long as the offender would have been locked up.

Yet naltrexone is rarely used inside or outside the criminal justice system. One reason is a limitation applicable to any medication which deprives patients of valued experiences: the more effective it is, the more patients simply refuse it or quickly abandon the treatment. Again this seems to make the treatment suitable for sentenced offenders, by definition already coerced into situations they would not have chosen. Let's examine this apparently suitable marriage between treatment and patient.

Overcoming resistance

There are at least three ways to overcome reluctance to start or continue with naltrexone. For convicted offenders, these could coalesce into a powerful treatment. The first is technical – the availability of long-acting naltrexone products which once inserted in the body more or less consign the patient to a period when opiate effects are blocked; they cannot (or not easily) stop the medication, even if they want to. Among treatment populations willing to try these products, they prevent illegal opiate use better than placebos or naltrexone pills which patients can simply stop taking. Deterring their use, long-acting products have not been licensed for medical use in the UK, but can still be prescribed.

The second way to overcome non-compliance is psychological – to engender the motivation to take naltrexone by making it worth the patient's while in order to gain positive or avoid negative consequences. Third are social influences – the availability and commitment of someone with influence over the patient to encourage them take the pills and monitor whether they do.

All three ways to prevent naltrexone being neutralised by non-compliance can in theory be marshalled for opioid-dependent offenders under criminal justice supervision. Long-acting implants or injections should be as available to them as to other patients, the prospect of early release from prison or avoidance of a more unpalatable sentence might be a powerful motivation-generator, while criminal justice staff – or treatment personnel reporting to them – can insist on frequent contact to bolster motivation and supervise administration of the pills or renewal of implants/injections.

But is it ethical?

However, because something can be done does not mean that it should be. With naltrexone, ethical misgivings about pressuring people into treatment – ultimately aimed at benefiting not them but society at large – are sharpened by its potential danger. If it does not also succeed in preventing relapse, any procedure which erodes opioid-dependent patients' capacity to tolerate high doses by successfully interrupting use of the drugs leaves those patients at heightened risk of fatal overdose. Naltrexone may further aggravate the risk because patients who stop taking it in order to resume heroin use can find that same ineffective dose they took hours before is later fatal as the blockade weakens. Death rates can be extremely high (1 2) – one reason why UK national guidelines caution careful selection of detoxification patients whose psychological resilience and social supports have been bolstered and who have supportive and stable social environments to go to after discharge.

The problem is that heroin-dependent patients in general lack these kinds of supports, and convicted offenders may lack them even more, raising ethical concerns about leveraging their restricted freedom to persuade them to accept naltrexone-based treatment. Part-funded by US government agencies, so prominent had this question become that in 2006 an issue of the *Journal of Substance Abuse Treatment*

devoted a special section to "Mandating Naltrexone Among Court-Referred Patients: Is It Ethical?"

> *Naltrexone inserts tie the patient's hands, preventing them terminating the treatment*

Summarised here, the supplementary text in the relevant section of the hot topic gives you a detailed account. Generally agreed is that given safeguards, it is ethically defensible to offer the choice of naltrexone-based treatment if this qualifies an offender for a more lenient sentence than would otherwise be imposed, such as early parole from prison or probation instead of imprisonment. This option has even been lauded as extending the offender's choices rather than restricting their autonomy. Still there are concerns that long-acting inserts in the body tie the patient's hands, preventing them terminating the treatment even if they want to, and that treatment has been subverted to criminal justice objectives rather than the good of the patient. Among the safeguards considered mandatory is that naltrexone be just one of a menu of options, which in the UK would include methadone and other opiate substitutes, almost certain to scupper naltrexone's chances with all but a few offenders.

In contrast to the Hobson's choice considered above, usually rejected as unethical is forced treatment over which the patient has no choice. But again there are dissenting voices, arguing that this might be acceptable as long as by restricting the patient's freedom to experience opioid effects, naltrexone extends their autonomy by freeing them from the cravings that constrict and dominate their life; "Infringing autonomy to create autonomy". Also, the case was made that forced intervention is a more caring response than leaving the helplessly addicted to their own destruction and that of others. Counter-arguments are that the 'addict' retains their freedom to choose, and not having lost this, does not need it 'restored' by naltrexone, that the medication has not been shown to dampen cravings which lead to relapse when the treatment ends, and that this line of thinking would justify ignoring patients' wishes and forcing treatment on the over-eater or those exhibiting obsessive-compulsive tendencies – a slippery slope to the erosion of autonomy.

Does it work?

Summarised here, the supplementary text in the relevant section of the hot topic gives you a study-by-study account of the evidence on naltrexone treatment for offenders.

Among the studies, two randomised trials from the USA (1 listed above; 2) are critical because they sampled offenders living in the community under criminal justice supervision, the main use envisaged for naltrexone. Both recorded marginally significant reductions in the proportions of offenders who violated parole attributable to adding an oral naltrexone programme to usual procedures. A review found these results amalgamated to a clearly significant reduction. Parole violation was the only measure of criminality which could be amalgamated, but in the second study there were others which gave a different picture – notably records rather than self-reports of parole violations (not significantly reduced) and the non-significantly but considerably more (32% v. 10%) naltrexone offenders charged with drug offences during the six-month follow-up.

As a whole, these and other studies show how few (previously) opioid-dependent offenders opt for naltrexone, even when opiate substitutes like methadone are not on offer, but also that when naltrexone administration is supervised, when offenders want it, have strong incentives to comply, and the treatment is active, it helps suppress opioid use and prevent parole or probation violations, affording offenders opportunities for learning to live opioid-free in the community which may otherwise be denied them. Without these conditions, rejection and drop-out from the programmes becomes the norm. Even with them, there seems no evidence that the substance use and parole/probation violation gains made while naltrexone is active persist after treatment ends, or (perhaps related) that they automatically extend to the stabilisation and improvement of other aspects of the patients' lives. As would be expected, long-acting naltrexone products are particularly effective while active among the few prepared to accept them (1 listed above; 2).

Over to you

If you have read not just this 'bite' but the more meaty hot topic, you have had a chance to absorb what we think is the most comprehensive and up to date introduction to the ethics and effectiveness of naltrexone treatment for offenders. Having benefited from this evidence and expert opinion, where do you stand? Is it

OK to force this treatment on the unwilling because by freeing them of their addiction it extends their autonomy? Or only OK if the offender can choose naltrexone as part of a less onerous sentence than they would otherwise have been given? Do we have enough evidence that naltrexone-based treatment works to feel comfortable about pressurising *anyone* to accept it? Should we also offer better established alternatives like methadone maintenance, even if this means naltrexone will rarely be chosen, and even if methadone-maintained patients commonly break the law by taking heroin once in a while? Are we missing a trick by not more widely forcing or pressuring opioid-dependent offenders to take naltrexone under supervision or to be fitted with long-acting implanted or injected naltrexone products? These products, after all, force an interruption in regular opioid use which may not be achievable by any other feasible means, and which could be used to embed opioid-free ways of coping. Or is this an ethically and perhaps also physically dangerous subversion of treatment to criminal justice ends, when medicine is supposed to prioritise the patient's welfare? But perhaps this is – despite their contrary wishes – the best way to safeguard some patients, rather than leaving them (and those around them) to descend deeper into the consequences of a destructive addiction – like forcibly holding back someone about to walk off the edge of a cliff – *even if that is what they choose to do*? If you have any answers, we'd like to hear them – email the editors at Drug and Alcohol Findings with your comments.

> *Like holding back someone about to walk off the edge of a cliff – even if that is what they choose to do*

Thanks for their comments on this entry to Colin Brewer, a psychiatrist based in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

 **Close Matrix Bite**