



Confronting reality: opportunities to address injecting drug use in correctional settings

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Key messages

- Half of all Australian prisoners report having injected drugs.
- Prisoners with injecting drug use (IDU) histories typically have poor physical health, mental health co-morbidities and high rates of blood borne virus infection; up to 60% test antibody positive for hepatitis C (HCV), indicating past or present infection.
- Evidence-based programs to reduce IDU and related harm in prisoners will likely be cost-effective and reduce the health and social burden of drug use and incarceration.
- Social disadvantage and a return to IDU following release are common and linked to reoffending (recidivism); two-year re-incarceration is as high as 85% among people who inject drugs.
- Justice systems will therefore benefit from sharing responsibility for the delivery and appropriate resourcing of relevant prison and transition programs, including:
 - i) opioid substitution therapy (OST) and other drug treatment programs, which have demonstrated effectiveness for reducing drug injecting, syringe sharing, overdose and contact with law enforcement;
 - ii) initiatives to retain prisoners in treatment programs in prison, through transition and in the community given the effectiveness of programs relies heavily on retention; and
 - iii) prison programs that facilitate and support functional post-release social and living environments, such as support for long-term stable accommodation.
- OST should be available at prison entry for all remand and sentenced prisoners currently on community-based OST programs. Appropriately managed OST initiation should also be available during incarceration.
- Returning to IDU following release is associated with high rates of overdose mortality. Strategies to help prevent post-release overdose should be supported, including:
 - i) pre-release overdose education;
 - ii) maintenance of OST through transition; and
 - iii) trialling pre-release and peer distribution of Naloxone, an overdose reversal drug.
- Based on strong international evidence, policy makers should consider needle and syringe programs in Australian prisons and explore models that address occupational health and safety concerns.

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What is the issue?

People with a history of injecting drug use (IDU) are grossly over-represented in prison; an estimated 1.8% of adult Australians report ever having injected drugs,¹ whereas about half of Australian prisoners report a history of IDU.² Criminal offending behaviours are closely linked with IDU, with about one in four police detainees attributing their offending to heroin use.³ Recidivism and re-incarceration is the norm among people who inject drugs; a recent NSW study showed 85% of prisoners with a history of heroin use were re-incarcerated within two years of release from prison.⁴

Poor general health among prisoners is compounded among those with a history of IDU. High mental health co-morbidities and extremely high prevalence of blood borne viruses (BBVs) among Australian prisoners (~60% HCV) and 30% hepatitis B (HBV) prevalence among those with a history of IDU² are of particular concern.

Surveys of prisoners in Australia^{5,6} and internationally⁷ indicate a notable proportion of prisoners report IDU in prison. High BBV prevalence and continued IDU in prison without access to clean injecting equipment underscore the high HCV-risk environment prisons represent. Alongside high rates of post-release risk behaviours, IDU in prison and the associated HCV transmission potentially plays a role in sustaining the HCV epidemic in the community.

People who inject drugs therefore represent a considerable proportion of the economic, social, health and community burden associated with incarceration.

What steps can be taken to address the issue?

Evidence-informed policies to prevent IDU-related harm and problematic patterns of IDU in prison and post-release will offer substantial health, community, criminal justice and economic benefits. Australia's most recent National Drug Strategy (2010-2015) and National Corrections Drug Strategy (2006-2009) emphasises a harm minimisation approach in responding to drug use; this approach contains the three key principles of supply reduction, demand reduction and harm reduction.

Correctional systems need to include strategies and programs that:

- Provide a supportive environment in prison to help prevent IDU among people who inject drugs and the initiation of IDU in prison;
- Provide a supportive environment in prison to help prevent the harms associated with IDU both in prison and post-release; and
- Ensure prisoners are supported when they transition back to the community and support is sustained to prevent a return to problematic patterns of drug use.

Key to the achievement of these strategic outcomes is the provision and appropriate resourcing of high quality prison drug treatment programs, pre-release and transition support programs, BBV prevention interventions and overdose prevention initiatives. These priority areas are addressed in the following sections.

Given the high rates of recidivism and re-incarceration among people who inject drugs, corrections policy makers must share responsibility for supporting programs delivered to people with a history of IDU in the period following release from prison and acknowledge the individual, social, economic and criminogenic benefits such programs provide.

Drug treatment programs in prison

OST remains the mainstay of IDU-related treatment programs in Australian prisons. Combinations of methadone, buprenorphine and suboxone dispensing are available in prisons in all Australian jurisdictions.

The evidence is extremely strong in support of OST for reducing a range of IDU-related harms in the community. Prison and community OST programs have been shown to reduce drug use, BBV transmission, post-release mortality, crime/reoffending and re-incarceration.^{8,9}

Australian jurisdictions place varying restrictions on the OST programs available within prisons, often citing the risk of diversion (the prescription drugs not being used as intended, e.g. for recreational or illegal purposes), as the basis for these restrictions.

To reduce such barriers to the provision of OST in prison, justice health policy makers and service providers need to keep abreast and consider latest innovations in pharmacotherapy dispensing types, including the development and trialing of suboxone film.

Restrictions are also in place in most jurisdictions regarding the eligibility of prisoners to receive OST. Principally, such restrictions refer to whether prisoners can be started on OST in prison or whether only those already receiving community-based OST at the time of prison entry are eligible for OST in prison. Given the strong evidence supporting the positive impact of OST, programs provided in correctional settings should be designed to reduce barriers to access, including appropriately managed initiation of OST in prison, and the availability of OST upon entry to all remand and sentenced prisoners.

Some prisoners express a preference for non-pharmacologically based drug treatment programs. These programs typically involve individual/group counselling, cognitive behavioural therapy (CBT) or therapeutic communities (TC). Little quality data exists regarding the effectiveness of such prison programs in reducing IDU and related harms. However, the provision of therapeutic counselling and support as part of a combination therapy approach can play an important role in maintaining adherence to other drug treatment programs.¹⁰⁻¹²

The benefits drug dependence treatment and other support programs accrue through sustained engagement; evidence shows that these programs are most effective in reducing drug use, mortality, crime and re-incarceration, and in promoting positive health outcomes when individuals are retained in programs over the medium to long term.^{4, 9, 13-15}

Pre-release support programs

It is broadly accepted that supportive post-release social and living environments away from criminal and drug using networks are crucial in supporting ex-prisoners to remain in drug treatment, avoid harmful patterns of drug use and to prevent recidivism and re-incarceration.¹⁶⁻¹⁸

It is crucial that correctional systems provide appropriately resourced pre-release programs that effectively support people with a history of IDU post-release. Such programs require close collaboration with community service providers and other relevant government departments and ideally include 'in-reach' programs to maintain continuity of care and service provision as people transition from prison to the community. Pre-release programs should:

- Highlight 'throughcare' as the key approach to planning and implementing in-prison and post-release services;
- Facilitate communication between prisoners and community-based workers during sentences, especially in the period leading up to release and after release;
- Support systems by which treatments or services (e.g., OST, HCV treatment) commenced in prison can be continued following release;
- Ensure the pre-release programs are highly visible and easy to access; and
- Develop systems whereby prisoners on short sentences and those on remand (typical among those incarcerated in drug-related charges) are able to access pre-release services or received facilitated links to post-release services.

Blood borne virus prevention

A combination of an overrepresentation of people with a history of IDU, HCV and HBV prevalence, and access to drugs without clean injecting equipment makes Australian prisons a major risk environment for BBV transmission.

Currently the only BBV prevention method available to prisoners who inject drugs in Australia is the provision of bleach to clean used needles and syringes. Limited laboratory and epidemiological evidence exists on the effectiveness of bleach for HIV prevention among people who inject drugs and there is no data supporting the use of bleach for HCV prevention. While the availability of bleach may be of certain benefit for BBV prevention in prison and should remain available, evidence suggests that bleach is considerably less effective when compared to access to clean injecting equipment.¹⁹

Prison needle and syringe programs (NSP) currently operate in ten countries, with many operating for more than ten years. Accumulated international evidence supports the contribution of prison NSPs to reducing BBV transmission and injecting-related injuries, reducing rates of overdose and mortality, and increasing uptake of drug treatment programs. Despite concerns to the contrary, no evidence exists showing prison NSPs increase drug use, and there have been no reported cases of needles and syringes being used as weapons in prisons where NSPs operate.

In light of this evidence and the support for prison NSPs in the *National Hepatitis C Strategy (2010-2013)*, various international covenants, and by professional organisations like the Australian Medical Association, policy makers should consider the introduction of NSPs in Australian prisons and explore potential models that address occupational health and safety concerns and support positive health and harm reduction outcomes for prisoners.

Post-release overdose prevention

Overwhelming evidence shows that release from prison represents an extremely high overdose risk period for people with a history of IDU. This risk is associated with a return to IDU in the context of reduced opioid tolerance. In addition to pre-release education programs to improve knowledge among prisoners of the factors that contribute to post-release overdose, there are two key pre-release approaches that can directly reduce post-release overdose risk.

First, numerous studies indicate reduced overdose risk if prisoners are maintained on OST to the end of their sentence and through transition to community based OST. Therefore, policies are needed that help retain prisoners on OST to the end of their sentence with seamless transition into community programs in order to reduce overdose risk and provide other demonstrable benefits.

The peer distribution and pre-release provision of Naloxone should also be considered in relation to preventing post-release overdose mortality. Such programs must be accompanied by appropriate training.

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