Impact, role, and prevalence of medication assisted treatment (MAT) for opioid users in European prisons

Barriers in the implementation of harm reduction interventions in European prisons. From evidence to practice

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No conflict of interest to declare

HIV-Prevention – The Comprehensive Package: 15 Key Interventions (UNODC et al. 2020)

Prevention of HIV, HBV and HCV

1. Information, education and communication
2. Condom and lubricant programming
3. Prevention of sexual violence
4. Needle and syringe programmes and overdose prevention and management
5. => Opioid substitution therapy and other evidence-based drug dependence treatment
6. Prevention of transmission through medical and dental services
7. Hepatitis B vaccination and prevention of transmission through tattooing, piercing and other forms of skin penetration
8. Post-exposure prophylaxis of HIV

HIV, hepatitis diagnosis and treatment

9. HIV testing and counselling services
10. HIV treatment, care and support
11. Diagnosis and treatment of viral hepatitis

Prevention, diagnosis and treatment of TB

12. Prevention, diagnosis and treatment of tuberculosis

Gender responsive services

13. Sexual and reproductive health
14. Prevention of mother-to-child transmission of HIV, syphilis and HBV

Occupational safety and health

15. Protecting staff from occupational hazards

[1]UNODC/ILO (2020 Update): HIV prevention, testing, treatment and care in prisons and other closed settings: a comprehensive package of interventions

OAT in Prison Settings (UNODC/WHO 2022)

- Initiation and continuation of OAT in prison and other closed settings is important.
- OAT in these settings supports people with opioid dependence to access treatment and avoid withdrawal.
- Linkage between prison and OAT services in community settings can improve continuity of OAT and reduce recidivism.

OST: evidence and progress

Evidences available for...[1]

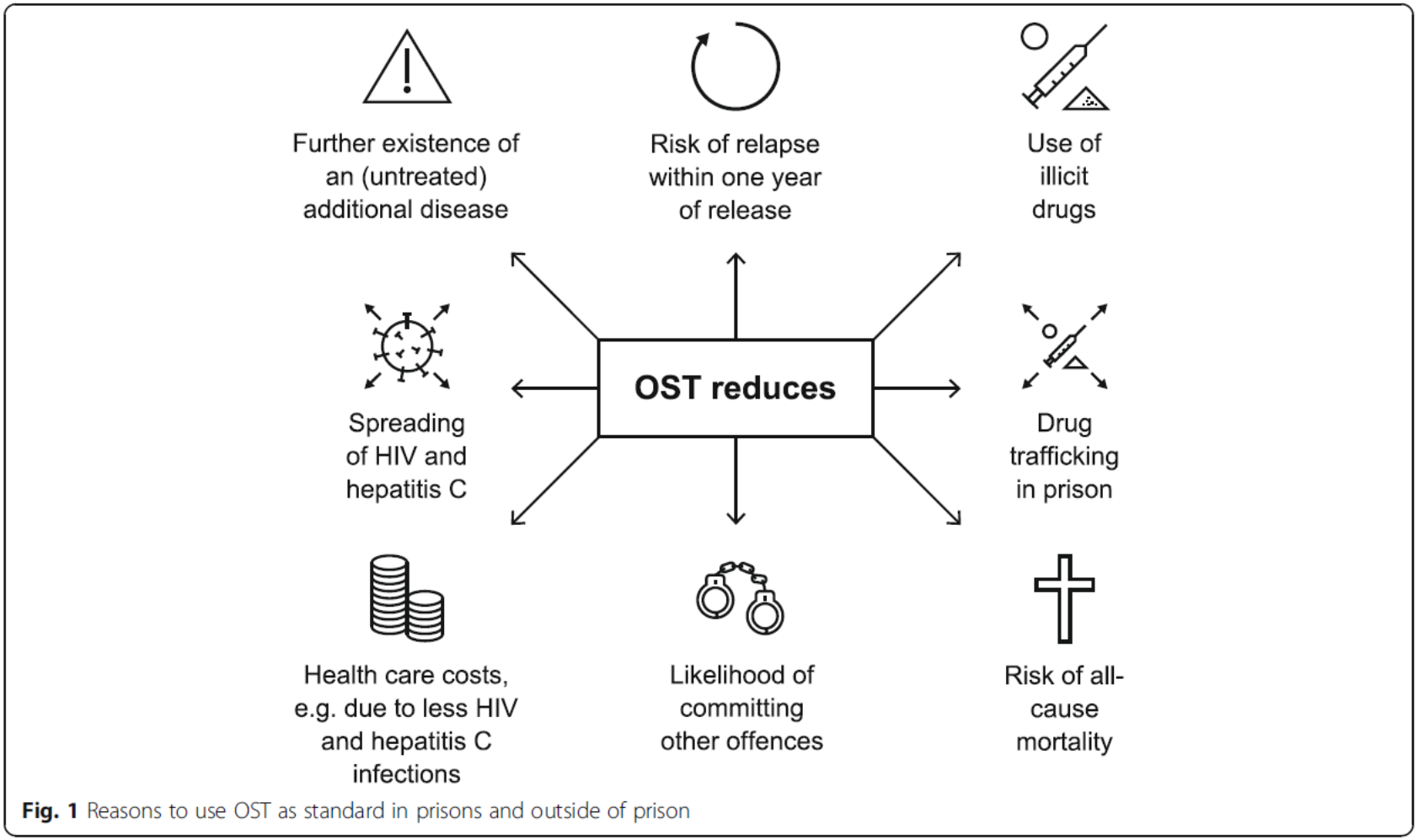


Fig. 1 Reasons to use OST as standard in prisons and outside of prison

1 Stöver, Heino; Jamin, Daniela; Michels, Ingo Ilja; Knorr, Bärbel; Keppler, Karlheinz; Deimel, Daniel (2019): Opioid substitution therapy for people living in German prisons - inequality compared with civic sector. Harm Reduction Journal, 16/72, DOI: 10.1186/s12954-019-0340-4

Evidence of OST in prisons[1]

One cohort study (Larney et al., 2014) enrolling N=16,715 opioid dependent people who were in prison between 2000 and 2012 showed that:

- being in OST was associated with a 74% lower hazard of dying in prison (adjusted HR (AHR) 0.26; 95% CI 0.13 to 0.50), compared to time not in OST
- being in OST was associated with a 87% lower hazard of unnatural death (adjusted HR (AHR) 0.13; 95% CI 0.05 to 0.35), compared to time not in OST
- being in OST was associated with a 94% lower all-cause mortality hazard during the first 4 weeks of incarceration (adjusted HR (AHR) 0.06; 95% CI 0.01 to 0.48), compared to time not in OST
- being in OST was associated with a 93% lower hazard of unnatural death during the first 4 weeks of incarceration (adjusted HR (AHR) 0.07; 95% CI 0.01 to 0.59), compared to time not in OST

1 EMCDDA 2021

Systematic OST review of prison[1]

- Review of 21 studies (incl. 6 RCTs) shows that OST is effective among the prison population:

++ reduced heroin use, injecting and syringe-sharing in prison, if doses adequate;

++ increases in treatment entry and retention after release;

++ post-release reductions in heroin use;

+ pre-release OST reduces post-release deaths;

+/- evidence regarding crime and re-incarceration equivocal;

? lack of studies addressing effects on incidence HIV/HCV;

Disruption of continuity of treatment, especially due to brief periods of imprisonment, associated with very sigificant increases in HCV incidence.

1 Hedrich et al. 2012; Addiction

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

RESEARCH REPORT

doi:10.1111/add.13779

Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England

John Marsden[1], Garry Stillwell[1], Hayley Jones[2], Alisha Cooper[3], Brian Eastwood[3], Michael Farrell[4], Tim Lowden[3], Nino Maddalena[3], Chris Metcalfe[2], Jenny Shaw[5] & Matthew Hickman[2]

Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK,[1] School of Social and Community Medicine, Faculty of Health Sciences, University of Bristol, Bristol, UK,[2] Alcohol, Drug and Tobacco Division, Health and Wellbeing Directorate, Public Health England, London, UK,[3] National Drug and Alcohol Research Centre, University of New South Wales, New South Wales, Australia[4] and Institute of Brain, Behaviour and Mental Health, University of Manchester, Manchester, UK[5]

Study participants

- 15,141 prison releases (12,260 people opiate dependent 'OUD')
  - 82.1% entered the study once; remainder re-entered 2 to 7 times due to re-incarceration
- *OST exposed:* 8,645 releases (57.1%)
  - 7,614 (88.1%) methadone (40 mg / day)
  - 1,031 (11.9%) buprenorphine (8 mg / day)
- *OST unexposed:* 6,496 releases (42.9%)
  - 2,369 people (36.5%) lower daily dose medication
  - 2,110 (32.5%) withdrawn from OST in prison
  - 2,017 (31.0%) diagnosed with current OUD but with no record of OST.

Conclusions

- Prison-based OST (with oral methadone or oral buprenorphine) is a highly effective means of **reducing the risk of death** (75% reduction) among people in the first 4 weeks after release from prison.
- The protective effect observed for OST in this study was independent of behavioural confounders or admission to community treatment.

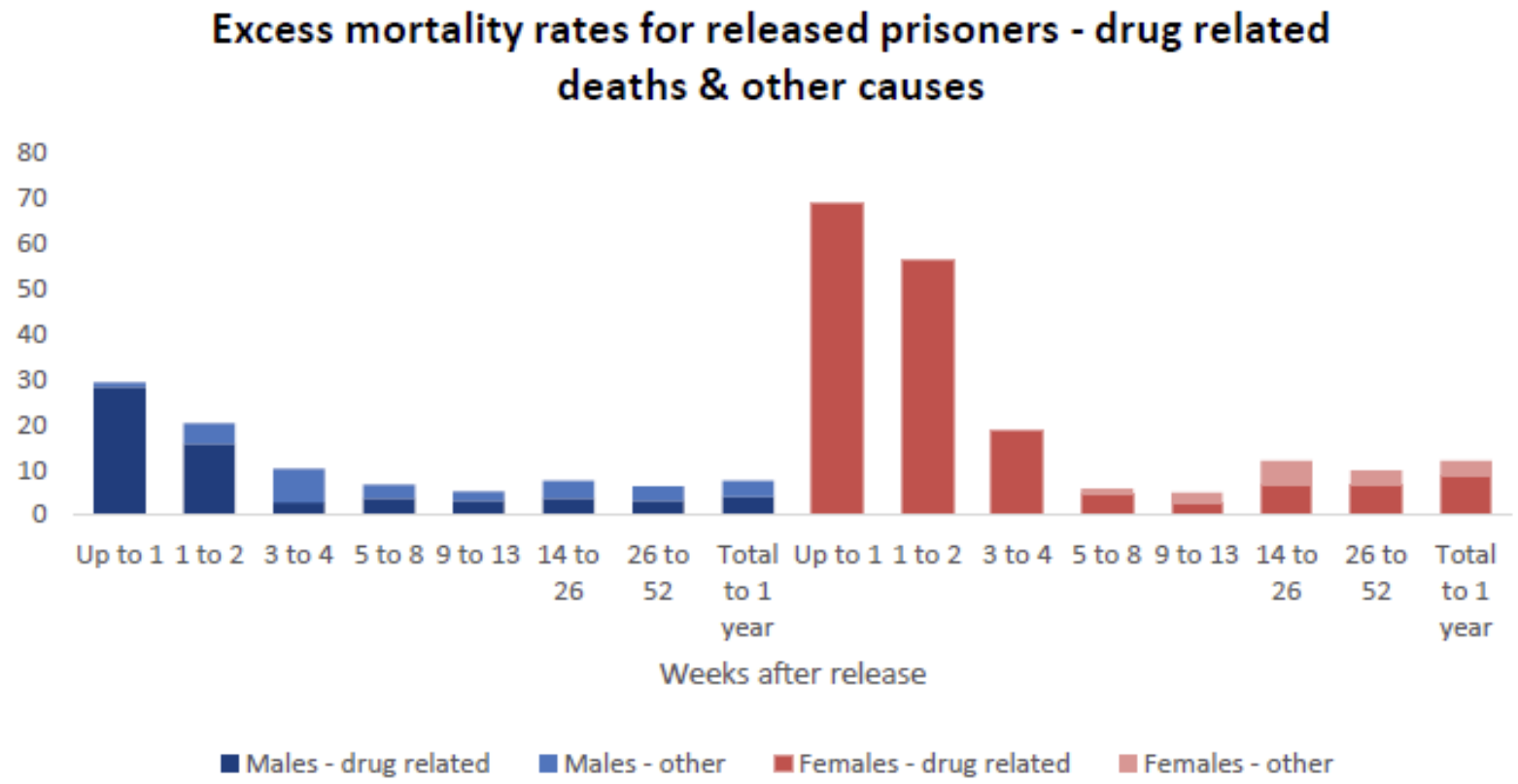
RESEARCH REPORT

doi:10.1111/j.1360-0443.2007.02081.x

Acute risk of drug-related death among newly released prisoners in England and Wales

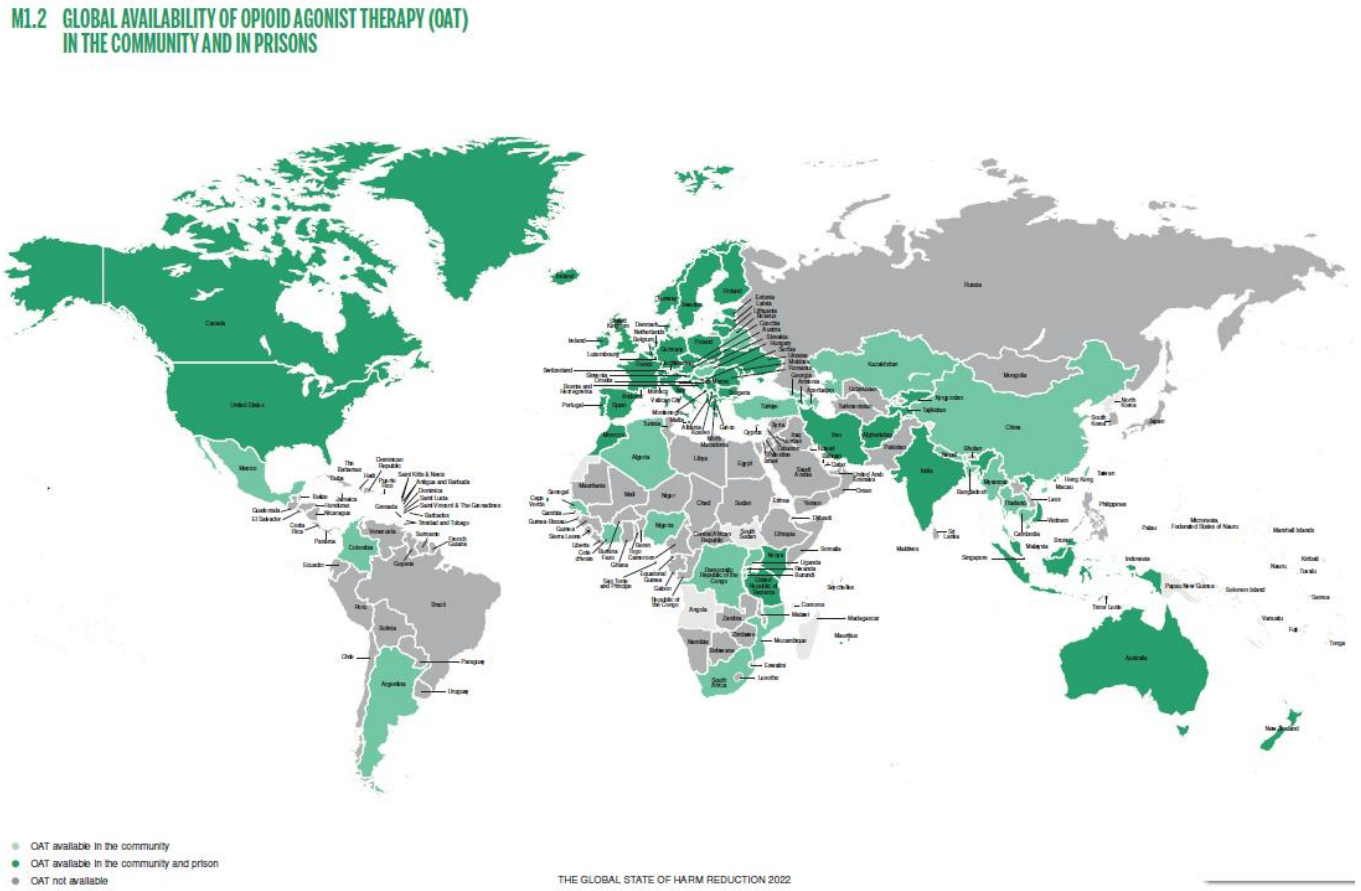
Michael Farrell & John Marsden *Addiction*, 103, 251–255

National Addiction Centre, Division of Psychological Medicine and Psychiatry, Institute of Psychiatry, King's College London, UK



Histogram from: Rebalancing Act: http://www.revolving-doors.org.uk/file/2049/download?token=4WZPsE8I

Global availability of OST in the community and in prisons[1]



Source: Harm Reduction International 2020
https://www.hri.global/files/2020/10/27/Global_State_of_Harm_Reduction_2020.pdf

Problems of implementation[1,2,3]

- Inequality compared with civic sector
- Percent of prisoners receiving OST increasing, but still low in many countries
- Rarely with psychosocial interventions
- Variable doses: same country, state, prison
- Lack of formal guidelines therapy recommendations
- The current delivery of OST in prisons shows inconsistencies and is often carried out in isolation from routine clinical assessments

1 EMCDDA: Linda Montanari 2017; **2** Alam et al. (2019): Optimising opioid substitution therapy in the prison environment; **3** Stöver et al. (2019): Opioid substitution therapy for people living in German prisons - inequality compared with civic sector. Harm Reduction Journal, 16/72

Problems of implementation I[1,2]

- Research evaluated in a scoping review on the implementation of OST in the criminal justice settings and/or with justice-involved populations demonstrates that barriers to OST implementation are pervasive, multi-leveled, and inter-dependent across correctional and community settings
- Disruption to the management of addiction and reduced treatment choice for OST adversely influences adequate provision of OST in prison.
- The following patient populations were identified as having concerns beyond their opioid use, and therefore require additional considerations in prison:
  - older people with comorbidities and complex treatment needs;
  - women who have experienced trauma and have childcare issues;
  - those with existing mental health needs requiring effective understanding and treatment in prison.

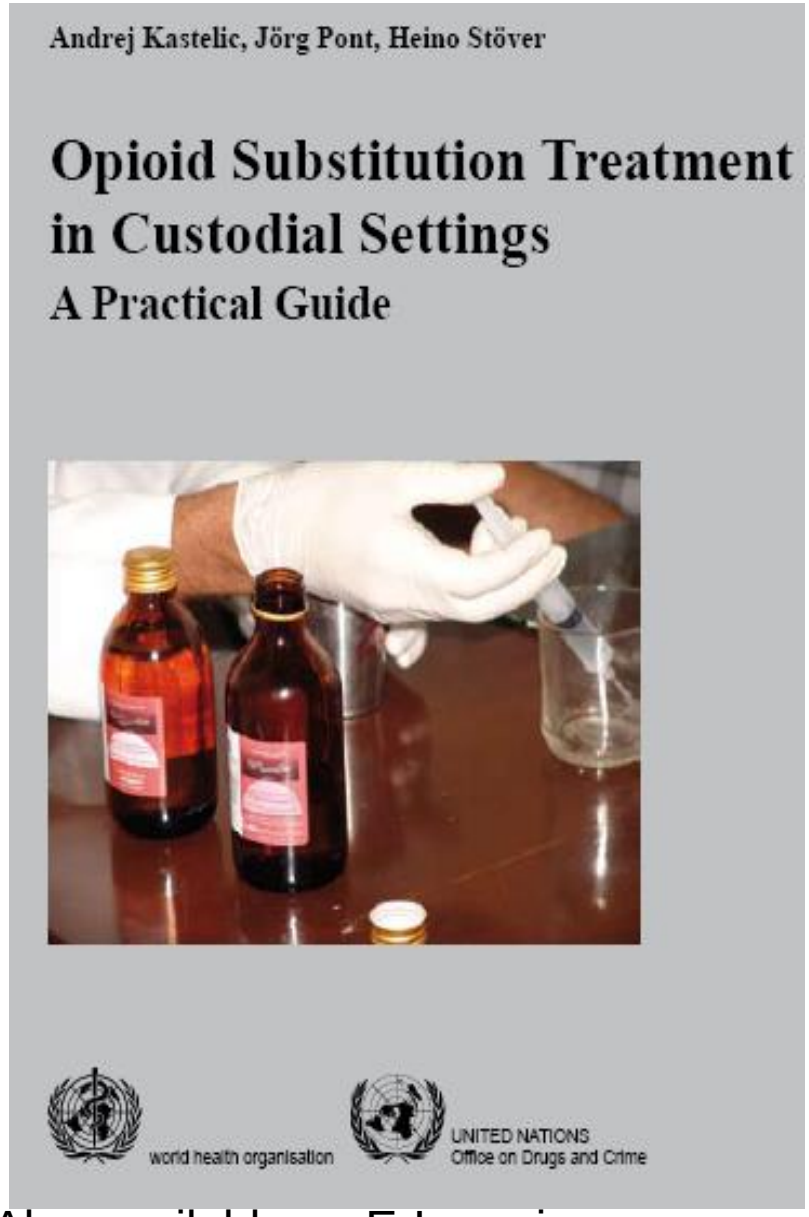
1 Grella et al. (2020): A Scoping Review of Barriers and Facilitators to Implementation of Medications for Treatment of Opioid Use Disorder within the Criminal Justice System; **2** Alam et al. (2019): Optimising opioid substitution therapy in the prison environment https://www.emerald.com/insight/content/doi/10.1108/IJPH-12-2017-0061/full/html

Barriers: Why is the introduction of OST going so slow[1]?

- Abstinence predominant concept
- Juridical concerns
- Lack of knowledge
- Lack of infrastructure
- Mixing up OST medications with street drugs by staff and medical doctors
- Political reasons

1 Stöver et al. 2020;

OST: how to overcome the obstacles of adequate implementation?



Also available as E-Learning course; see: www.harmreduction.eu

Adopted to the national situation and translated into several languages (e.g. Russian, Czech, Lithuanian, Latvian, Estonian, German, Turkish etc.)

Therapy recommendations, protocols, MoUs (Alam et al. 2019)

- Establish a clear OST strategy between care team and prisoner at the moment of arrival, noting the individual's specific needs;
- Ensure OST is prompt, reliable and adjustable
- Establish clear protocols for transition to the community on release, with no gaps in care, and no changes, and with adequate safeguards against overdose
- Integrate clinical and psychosocial care, using a full-team care plan that regards the prisoner as part of the team.

Risks: overdose and diversion

- Risk of overdose can be minimized by proper anamnesis (including information by treating doctor outside)
- Start low and go slow: dosing needs to be done individually
- Confirmation of identity
- Supervision of intake
- Many ways to prevent diversion
- Long acting medications available
  (1 week, 1 month, 6 months)

How to overcome the barriers?

- Reducing Stigma
- Offering psycho-social care
- Differentiation: Make use of the whole range of medications
- Personalization of treatment
- New long acting medications => Covid 19!
- Manualize treatment - protocols[1]

1 UNODC/WHO (2022): Establishing and Delivering Evidence-Based, High Quality Opioid Agonist Therapy Services. An operational tool for low and middle-income countries.:

How to overcome the barriers?

- Consensus statement[1,4] :uninterrupted treatment in custody, integrated with psychosocial care, and clear plans for what happens on release
- Treatment recommendations[2]
- Educational needs for healthcare providers and administration of OST[3]
- Inform and involve other staff members[3]
- Education of stakeholders[3]
- Training prisoners with experience of OST to provide peer support and advocacy

1 Gross, G. et al al. (2021): Reducing opioid dependence therapy risk in the prison system and the use of extended-release buprenorphine as an additional treatment option: A consensus statement. Heroin Addict Relat Clin Probl; **2** e.g. State of Northrhine-Westfalia/Germany; **3** Pompidou Group;: Moldova; **4** Orange Book: Independent Exoert Working Group 2017/UK .:

How to overcome the barriers?

- Involving doctors and NGOs from the community
- Involve people living in prisoners
- Continuity of OST after release

OST Quality Management:

- Availability of OST in your prison currently?
- Efficiency of OST service generally?
- Recent trends in prison OST provision?
- Extent of user/prisoner choice around substance, maintenance or withdrawal, and dose?

1 Gross, G. et al al. (2021): Reducing opioid dependence therapy risk in the prison system and the use of extended-release buprenorphine as an additional treatment option: A consensus statement. Heroin Addict Relat Clin Probl; **2** e.g. State of Northrhine-Westfalia/Germany; **3** Pompidou Group;: Moldova; **4** Orange Book: Independent Exoert Working Group 2017/UK; **5** Russel et al. (2022): **Barriers and facilitators to opioid agonist treatment (OAT) engagement among individuals released from federal incarceration into the community in Ontario, Canada**

How to overcome the barriers[1]?

- What are the practicalities in terms of choice and diversion of medication?
- What are the challenges facing OST programmes?
- What are the important features of best practice in OST provision?
- Alternate-day dosing possible?
- Injecting behaviours: OST plus Prison-Based Needle Exchange possible?[2,3]

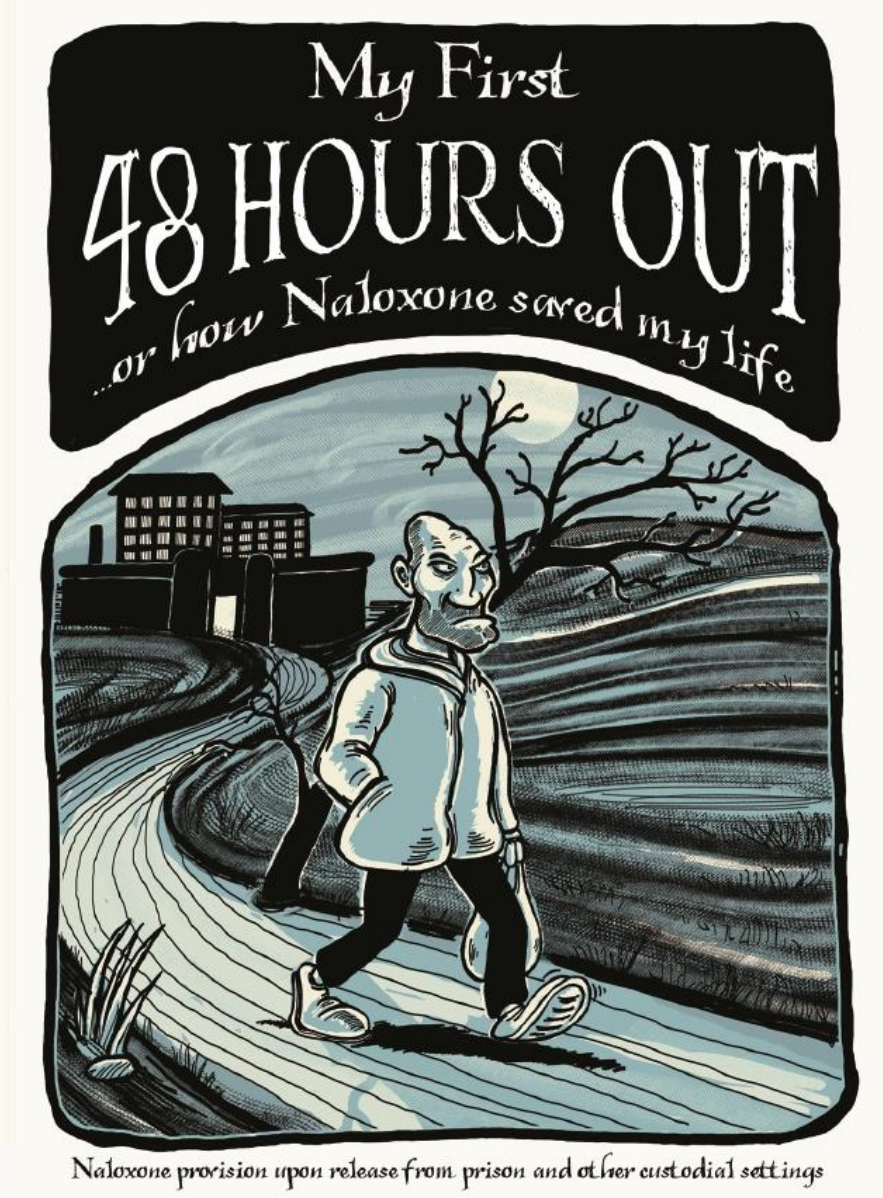
1 Alam et al. (2019) ; **2** Cunningham et al. 2018; **3** Lazarus, J.V., Safreed-Harmon, K., Hetherington, K.L., Bromberg, D.J., Ocampo, D., Graf, N., Dichtl, A., Stöver, H. and Wolff, H. (2018), "Health outcomes for clients of needle and syringe programs in prisons", Epidemiologic Reviews, Vol. 40 No. 1, pp. 96-104.

Topics (at least) to be tackled in OST recommendations[1]?

- **OST initiation**
- **Integrating clinical and psychosocial care in prisons**
- **Diverse prison populations need tailored provision of OST**
- **The older offender**
- **The mentally ill**
- **Women**
- **Ethnic and cultural minority populations**

1 Alam et al. (2019) ; **2** Cunningham et al. 2018; **3** Lazarus, J.V., Safreed-Harmon, K., Hetherington, K.L., Bromberg, D.J., Ocampo, D., Graf, N., Dichtl, A., Stöver, H. and Wolff, H. (2018), “Health outcomes for clients of needle and syringe programs in prisons”, Epidemiologic Reviews, Vol. 40 No. 1, pp. 96-104.

Combine with Take-Home-Naloxon



Conclusions

- Prison-based OST is a highly effective means of treating opioid use disorder
- OST is a starting point and stable therapy for treating other disorders and infectious diseases
- Highly effective of reducing the risk of death (75% reduction) among people in the first 4 weeks after release from prison.
- Principle of equivalence and continuity of care
- Should be combined with Take-Home-Naloxone

„... Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities “

(*Joint United Nations Programme on HIV/AIDS (UNAIDS) S*tatement on HIV/AIDS in Prisons)

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