Working Paper 2

Availability, Accessibility, Acceptability and Quality of Harm Reduction in Prisons:

A global review of the literature

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Overview

The right to health, in practice, implies reference to a framework that includes availability, accessibility, acceptability and quality of health services. For example, see general comment 14 on Article 12 of the International Covenant on Economic, Social and Cultural Rights.[1]

Equivalence is not a sufficient metric for prison health services, because of the excess morbidity experienced by people in prison.[2] Equivalence must be considered a minimum acceptable standard, not an ideal.[3]

Availability

Availability of services requires that public health and healthcare facilities are available in sufficient quantity, taking into account a country's developmental and economic condition.[4] Services should be available to all prisoners regardless of crime, gender, age, sentence length or other conditions.[5]

Harm reduction is less available in prisons than in the general population at the global level

59 countries worldwide provide OAT in prisons (70% of those which provide OAT in the community [n=84]; 33% of those with evidence of injecting drug use [n=179]).[6]

10 countries worldwide provide NSP in prisons (12% of those which provide NSPs in the community [n=86]; 6% of those with evidence of injecting drug use [n=179]).[7]

Harm reduction availability in prisons is uneven within countries

There are differences between prison systems. There are differences between federal and state/provincial/territorial prisons in Canada and the United States. NSPs are only available in Canadian federal prisons, and only 9% of state prisons and jails in the United States provide OAT.[8]

Different subnational prison systems can also vary. In Germany, OAT is widely available in Berlin, but barely available in Saxony and unavailable in Bavaria.[9]

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[1] Tim Exworthy et al., 'Asserting Prisoners' Right to Health: Progressing Beyond Equivalence', *Psychiatric Services* 63, no. 3 (1 March 2012): 270–75, https://doi.org/10.1176/appi.ps.201100256.
[2] Exworthy et al.
[3] Rick Lines, 'From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Health Care Standards Higher than Those Outside Prisons', *International Journal of Prisoner Health* 2, no. 4 (1 January 2006): 269–80, https://doi.org/10.1080/17449200601069676.
[4] 'AAAQ Framework – IFHHRO', accessed 28 July 2021, https://www.ifhhro.org/topics/aaaq-framework/.
[5] Babak Moazen et al., 'Availability, Accessibility, and Coverage of Needle and Syringe Programs in Prisons in the European Union', *Epidemiologic Reviews* 42, no. 1 (31 January 2020): 19–26, https://doi.org/10.1093/epirev/mxaa003.
[6] Harm Reduction International, 'The Global State of Harm Reduction 2020' (London: Harm Reduction International, 2020).
[7] Harm Reduction International.
[8] Harm Reduction International.
[9] Harm Reduction International; Gen Sander, Sam Shirley-Beavan, and Katie Stone, 'The Global State of Harm Reduction in Prisons', *Journal of Correctional Health Care* 25, no. 2 (1 April 2019): 105–20, https://doi.org/10.1177/1078345819837909.

Harm reduction availability can vary between prisons in the same prison system

In Canada, only 11 of 44 federal prisons provide NSP. Only 15 of Switzerland's 106 prisons (accounting for 21% of the prison population) provide NSP; heroin assisted therapy is available in only one Swiss prison.[10]

Available can depend purely on whether they have links to a physician prescribing OAT (e.g. in Canada).[11] Elsewhere, for example in Macedonia, availability can depend on individual projects carried out by non-governmental organisations.[12]

Availability can be more limited in police custody or pre-trial detention, compared with while serving custodial sentences[13]

Harm reduction may be made available to some but not all prisoners

Most commonly, availability of OAT can be limited to those who have already initiated before entering prison.[14] This is a formal limitation in: Albania, Cyprus, Jordan, Latvia, Lebanon, Montenegro, Morocco and Serbia; as well as in some prisons in Canada.[15]

Factors that limit availability of harm reduction in prisons

These include: opposition from prison staff (e.g. has prevented expansion in Canada) due to unfounded fears of diversion (of OAT) or threats to safety (from NSP)[16]; lack of prioritization and financing from government[17]; preference for focus on abstinence-based approaches to drug use[18]; belief that provision of syringes will increase to number of people injecting in prison, and that it amounts to a failure in controlling the presence of drugs in prisons.[19]

Accessibility

In the AAAQ framework can be identified four dimensions of accessibility:[20]

- Non-discrimination: services must be available to all, especially the most vulnerable
- Physical accessibility: services must be within safe physical reach of all
- Economic accessibility: services must be affordable for all
- Information accessibility: beneficiaries must have the right to seek, receive and impart information concerning health issues, with information delivered in an unbiased manner.

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[10] Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[11] Harm Reduction International.
[12] Rob Bielen et al., 'Harm Reduction and Viral Hepatitis C in European Prisons: A Cross-Sectional Survey of 25 Countries', *Harm Reduction Journal* 15, no. 1 (11 May 2018): 25, https://doi.org/10.1186/s12954-018-0230-1.
[13] Anna Buadze et al., 'The Accessibility of Opioid Agonist Treatment and Its Forced Discontinuation in Swiss Prisons—Attitudes, Perceptions and Experiences of Defense Lawyers in Dealing With Detained Persons Using Opioids', *Frontiers in Psychiatry* 0 (2020), https://doi.org/10.3389/fpsyt.2020.00395.
[14] Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[15] Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'; Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[16] Harm Reduction International, 'The Global State of Harm Reduction 2020'; Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'.
[17] Moazen et al., 'Availability, Accessibility, and Coverage of Needle and Syringe Programs in Prisons in the European Union'.
[18] Moazen et al.
[19] Moazen et al.
[20] Exworthy et al., 'Asserting Prisoners' Right to Health'.

The most common challenges to accessibility are stigma, a lack of trust between providers and clients, the design of prison services, and the level of resources available to services.[21] Data availability of coverage is poor, meaning that it can be difficult to make conclusions about accessibility across the board[22]

Opioid agonist therapy

Discrimination

Unfounded fears of diversion can lead to restrictive prescribing practices, based also in stigma and discrimination towards people who use drugs, as noted in at least Canada, Germany and Italy.[23] Access may also be limited based on restrictive clinical guidance that is not in line with international guidance, for example unavailable to pregnant women in some cases (e.g. most states of the US).[24]

People may also be reluctant to access OAT for fear of reprisals from other prisoners, noted in India, Indonesia and Malaysia.[25] In Iran, this has been linked to the initial criteria for enrolment (people living with HIV [related to homophobia], people who inject drugs).[26]

In Catalonia, the OAT programme considered to be low threshold, with very few conditions on enrolment.[27]

Physical accessibility

A lack of resources can lead to long waiting lists for OAT enrolment. The Greek prison OAT programme is by an NGO, and as of 2016 had five times as many people on the waiting list than enrolled in the programme.[28] Long waiting lists are also reported as a barrier in Portugal.[29]

In some cases, OAT services are located off site, meaning people rely on prison transport to take them to receive doses (e.g. in Malta, Palestine and Portugal).[30]

Information accessibility

Circulation of misinformation (e.g. fears of liver damage related to OAT and other side effects) prevents people from enrolling in Iran.[31]

Needle and syringe programmes

Discrimination

Issues related to stigma, discrimination and punishment related to outing themselves as a person who inject drugs in prison (noted in Romania[32]) and relatedly issues with confidentiality (e.g. in

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[21] Exworthy et al.
[22] Moazen et al., 'Availability, Accessibility, and Coverage of Needle and Syringe Programs in Prisons in the European Union'.
[23] Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[24] Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'.
[25] Sander, Shirley-Beavan, and Stone.
[26] Saman Zamani et al., 'A Qualitative Inquiry into Methadone Maintenance Treatment for Opioid-Dependent Prisoners in Tehran, Iran', *International Journal of Drug Policy* 21, no. 3 (1 May 2010): 167–72, https://doi.org/10.1016/j.drugpo.2009.03.001.
[27] Gen Sander et al., 'Overview of Harm Reduction in Prisons in Seven European Countries', *Harm Reduction Journal* 13, no. 1 (7 October 2016): 28, https://doi.org/10.1186/s12954-016-0118-x.
[28] Sander et al.
[29] Sander et al.
[30] Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'.
[31] Zamani et al., 'A Qualitative Inquiry into Methadone Maintenance Treatment for Opioid-Dependent Prisoners in Tehran, Iran'.
[32] Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'.

Catalonia,[33] only 5-6% of people who inject drugs in prison are estimated actually to use prison NSPs[34]) can prevent people from accessing NSPs.

Models of NSP that require people present to health or prison staff may lead to reduced uptake because of a lack of anonymity (noted in Portugal and Germany). Models using syringe dispensing machines may address this.[35]

Physical accessibility

There can be conflicts between NSP provision by health staff and a zero tolerance policy on drugs among security staff (e.g. in Canada[36]). In Catalonia, cell inspections that find altered or damaged injecting equipment can lead to punishment, meaning people are reluctant to use the services (also related to acceptability of equipment, see below).[37]

In a two month pilot in programme in Portugal, not a single prisoner participated for fear of reprisals from prison staff (and prison staff reported this fear was well founded).[38]

Naloxone

People in prison in the UK must specifically request to participate in naloxone-on-release training, but many choose not to because of a perceived risk they will be denied parole if they show intent to use illicit drugs.[39]

Acceptability

Acceptability means services must be ethically and culturally appropriate to all those who access them, including those from marginalised groups.[40]

Opioid agonist therapy

No literature was found specifically assessing the acceptability (or lack thereof) of OAT services in prison.

Needle and syringe programmes

In principle, prison NSPs are highly acceptable. For example in Canada, 16% of respondents in one survey brought up NSP unprompted as a desirable harm reduction intervention, a higher proportion than identified as injecting drug users.[41]

There can be issues in acceptability related to the commodities offered in NSPs. For example, in Catalonia, the absence of bowls from the package of injecting equipment means people do not use the services, and the provision of inappropriate or inadequate equipment leads to people altering them themselves.[42]

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[33] Sam Shirley-Beavan et al., 'Women and Barriers to Harm Reduction Services: A Literature Review and Initial Findings from a Qualitative Study in Barcelona, Spain', *Harm Reduction Journal* 17, no. 1 (19 October 2020), https://doi.org/10.1186/s12954-020-00429-5.
[34] Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'.
[35] Moazen et al., 'Availability, Accessibility, and Coverage of Needle and Syringe Programs in Prisons in the European Union'.
[36] Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[37] Shirley-Beavan et al., 'Women and Barriers to Harm Reduction Services'.
[38] Sander et al., 'Overview of Harm Reduction in Prisons in Seven European Countries'.
[39] Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[40] Exworthy et al., 'Asserting Prisoners' Right to Health'.
[41] Laurene Rehman et al., 'Harm Reduction and Women in the Canadian National Prison System: Policy or Practice?', *Women & Health* 40, no. 4 (2004): 57–73.
[42] Sander, Shirley-Beavan, and Stone, 'The Global State of Harm Reduction in Prisons'.

Naloxone

Take-home naloxone training on release has been found to be overwhelmingly acceptable to people who use drugs (for example, in Australia), particularly among those who inject while in prison.[43]

Quality

High quality services must be scientifically and medically appropriate, have a highly skilled workforce sustained through investment and training.[44]

Opioid agonist therapy

In some contexts, a lack of qualified staff is a significant limitation on the quality of OAT in prisons. For example, in Latvia research finds a lack of education and knowledge about drug use and harm reduction among prison staff.[45] In Ireland, prison OAT was considered high quality – and equivalent to standards outside prison – in only one prison as of 2016, where six specialist nurses had distinct roles in addressing drug dependence and services were provided by a multi-disciplinary expert team. However, quality was not observed to be equivalent in other prisons.[46] In Iran, a shortage of health staff has led to long waiting lists for enrolment on OAT. Prison health policymakers have called for increased coverage, but this cannot be provided by staffing levels without sacrificing quality of services.[47]

Elsewhere, prison OAT is dominated by an abstinence-led agenda, making is a less effective harm reduction measure. This is exclusively the case in Georgia, Hungary and Poland[48], where prison OAT is only available when targeting abstinence.[49] In Switzerland, defence lawyers interviewed viewed abstinence and tapering as a natural part of courses of OAT.[50]

Standards of care are sometimes different in prison to outside. In Portugal, reports suggest that in some cases OAT is not provided in accordance with national guidelines in prisons.[51] In Switzerland, OAT can be insufficient with regard to dosage, especially in pre-trial detention. People are not empowered to make decisions or have influence about their own dosage, and there have been cases where withdrawal symptoms have been treated with benzodiazepines instead of OAT. Additionally, reduction of dosage can be used as a disciplinary measure.[52] In Catalonia, there are reports of overmedication, with perceptions that OAT and benzodiazepine dosage is used to pacify people in

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[43] Michael Curtis et al., 'Acceptability of Prison-Based Take-Home Naloxone Programmes among a Cohort of Incarcerated Men with a History of Regular Injecting Drug Use', *Harm Reduction Journal* 15, no. 1 (21 September 2018): 48, https://doi.org/10.1186/s12954-018-0255-5.
[44] Exworthy et al., 'Asserting Prisoners' Right to Health'.
[45] Sander et al., 'Overview of Harm Reduction in Prisons in Seven European Countries'.
[46] Sander et al.
[47] Zamani et al., 'A Qualitative Inquiry into Methadone Maintenance Treatment for Opioid-Dependent Prisoners in Tehran, Iran'.
[48] Sander et al., 'Overview of Harm Reduction in Prisons in Seven European Countries'.
[49] Harm Reduction International, 'The Global State of Harm Reduction 2020'.
[50] Buadze et al., 'The Accessibility of Opioid Agonist Treatment and Its Forced Discontinuation in Swiss Prisons—Attitudes, Perceptions and Experiences of Defense Lawyers in Dealing With Detained Persons Using Opioids'.
[51] Sander et al., 'Overview of Harm Reduction in Prisons in Seven European Countries'.
[52] Buadze et al., 'The Accessibility of Opioid Agonist Treatment and Its Forced Discontinuation in Swiss Prisons—Attitudes, Perceptions and Experiences of Defense Lawyers in Dealing With Detained Persons Using Opioids'.

prison.[53] In Iran, research suggests there has been a lack of after care or support with referrals to non-prison OAT programmes for people leaving prison.[54]

Needle and syringe programmes

Equipment supplied can be insufficient to prevent infections, for example in Catalonia programmes do not provide cookers, therefore people continue to use unsterile equipment at are at risk of infections.[55]

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