



## FOCUS ON HARM REDUCTION FOR INJECTION DRUG USE IN CANADIAN PRISONS: A SUPPLEMENT TO CNA'S HARM REDUCTION DISCUSSION PAPER

### NEEDLE SHARING AND SUBSTANCE USE IN PRISONS

#### Introduction

Prison populations in Canada and around the world have high rates of reported drug use and significantly higher occurrences of communicable diseases such as HIV and HCV (hepatitis C). Harm reduction for injection drug use, delivered through needle and syringe exchange programs, is an effective and pragmatic public health approach to caring for people in prison who use drugs. Nurses have an ethical responsibility to provide non-judgmental care to individuals experiencing (or at risk of) harm from substance use, regardless of setting,<sup>1</sup> while emphasizing human rights and the importance of treating all individuals with respect and dignity, irrespective of drug use.

#### Prison health — An international picture

Globally, prison health has become an important public health issue given the rising and rapid spread of HIV infection and AIDS, tuberculosis, HCV and “the increasing recognition that prisons are inappropriate environments for people with substance dependence and mental health issues” (WHO, 2009, p. viii). National strategies adopted to control the spread of disease require effective prison policies just as good prison health practices seek to prevent the spread of disease and promote health and well-being (WHO, 2009). Yet prison health services vary substantially throughout the world. In discussing the prevalence of needle-sharing in prisons around the world, WHO (2009) reported that:

- ▶ the rates of injecting drugs and needle sharing vary significantly
- ▶ individuals who use drugs before incarceration will often stop or reduce their levels of use in detention; but many resume injecting upon release
- ▶ many incarcerated individuals start injecting drugs in prison
- ▶ people who inject drugs in prison are much more likely to share injecting equipment.

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<sup>1</sup>As stipulated in the CNA code of ethics (2008), which guides ethical nursing practice for registered nurses.

The high rates of injection drug use, coupled with lack of access to preventive health care, can result in elevated and widespread HIV rates. WHO (2009) noted a number of documented HIV outbreaks in prisons across several countries, including Australia, Lithuania, the Russian Federation, Scotland and the U.K. The first such outbreak within a prison population occurred in Scotland in 1993, where “43% of inmates reported injecting [drugs] within the prison — and all but one of these individuals had shared injecting equipment within the prison (Taylor & Goldberg, 1996). According to WHO (2009) figures from a number of studies put the rates of incarcerated individuals who began injecting drugs in prison between 7 and 24 per cent.

WHO’s (2009) recommendations on how to achieve better health outcomes in prisons were based on best-practice evidence, an extensive review of the scientific and grey literature, and advice from key experts. Among these recommendations was to introduce comprehensive HIV programs that prevent new infections by:

- ▶ reducing sexual transmission of disease through improved life skills and access to condoms
- ▶ implementing needle and syringe programs to reduce HIV transmission by sharing contaminated injecting equipment
- ▶ peer-based education
- ▶ mitigating HIV-related diseases through appropriate care, treatment and support for HIV and related diseases
- ▶ undertaking measures to counter HIV-related stigma and discrimination
- ▶ conducting surveillance of HIV and AIDS
- ▶ providing easy access to voluntary HIV counselling and testing.

## **Prison health in Canada**

In Canada, prisons fall under a shared jurisdiction between federal and provincial/territorial governments. Each year, more than 250,000 adults are admitted to prisons, and about 40,000 people are in prisons on any given day (Kouyoumdjian, Schuler, Matheson, & Hwang, 2016). As a group they experience inequities in health and health access that are further compromised by incarceration.

Populations that experience health inequities due to social and structural inequities are overrepresented in Canadian prisons. The federal prison population consists of “a disproportionate number of people from low-income backgrounds, [who] have less formal education than the general population and [often have complex] mental health care needs. Most federally incarcerated women have also experienced sexual and physical abuse [and have higher] substance use and depression [rates] than men” (van der Meulen et al., 2016, p. 5). The proportion of Indigenous persons in the Canadian penal system is especially imbalanced. For example, using figures from 2013-2014, despite making up only three per cent of the Canadian adult population, Indigenous adults represented 20 per cent of admissions to federal prisons, 24 per cent in the provinces and territories (Statistics Canada, 2015a). This disproportion was even greater

among Indigenous youth, who made up seven per cent of the youth population<sup>2</sup> while representing 41 per cent of prison admissions (Statistics Canada, 2015b). The disparity was higher still for Indigenous girls, who accounted for 53 per cent of female youth in corrections, compared with 38 per cent for Indigenous male youth (Statistics Canada, 2015b).<sup>3</sup> While, internationally, the UN (1990) has stipulated that “prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation” (Annex, para. 9), these obligations have not been consistently met in Canada (Kouyoumdjian et al., 2016; Miller, 2013; Flegel & Bouchard, 2013).

As the data on “social determinants of health, mortality in custody, mental health, substance use,” and blood-borne disease transmissions indicates (Kouyoumdjian et al., 2016), the health status of incarcerated individuals is poor when compared with those in Canada’s general population. This includes chronic disease, infectious and blood-borne diseases, and mental health and substance use issues. The prevalence of HIV is estimated to be 10 times higher among people in prison while, for HCV, it is 30 to 39 times higher (van der Meulen, Claivaz-Loranger, Clarke, Ollner, & Watson, 2016). The Office of the Correctional Investigator of Canada (OCIC, 2015) reported that, in 2014-2015, more than half of federal inmates showed signs of substance dependence (drug or alcohol) and 16.5 per cent had HCV. Many individuals also have a history of drug use prior to incarceration. OCIC (2014) noted that, upon admission, 80 per cent of federally incarcerated individuals had a serious substance use problem, and more than half said drugs or alcohol was a factor in their offence. In addition, according to DeBeck et al., (2009), 30 per cent of women and 14 per cent of men in federal prisons were incarcerated on drug-related charges.

In Canada’s jurisdictions, the delivery of health care in prisons varies by province and territory. For example, in Nova Scotia and Alberta health care is delivered by the provincial authority for health while, in Ontario, it is carried out by the government responsible for corrections. In B.C. health care is contracted out to a private company (Kouyoumdjian, et al., 2016). This inconsistency across the country serves as an additional barrier to care for populations that already face significant health inequities.

It is critical to address health inequities through a social justice lens that draws our attention to the wider policy changes that are needed. As is shown in the *Safe Streets and Communities Act* (2012), the federal government continues to see drug use as a criminal justice issue rather than a concern of health and social justice (CNA, 2011; Canadian Public Health Association, 2014). A significant amount of research shows that the current approach of criminalizing substance use disproportionately accelerates its

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<sup>2</sup> For reporting jurisdictions

<sup>3</sup> Correctional services for youth in Canada are guided by federal legislation (the *Youth Criminal Justice Act*), and administered by the provinces and territories. Standards for health care are defined in federal acts — for example, the *Corrections and Conditional Release Act* or the *Canada Health Act* (which remains applicable to health-care delivery in provincial facilities).

associated harms (Human Rights Watch, American Civil Liberties Union, 2016). Yet, despite the adoption of zero-tolerance strategies and increased drug testing in federal prisons, drug use rates remain high (OCIC, 2015). As a result, Canada's correctional investigator has recommended that more resources be allocated to treatment, prevention and harm reduction strategies (OCIC, 2015). Such trends clearly indicate the limitations of an approach that criminalizes illegal drug use.

## Needle exchange and harm reduction programs in prisons

The Canadian federal prison system currently offers some forms of harm reduction programming, including "opiate substitution treatment (e.g., methadone), bleach, condoms, and some educational materials for [incarcerated individuals] regarding how to reduce the possibility of HIV or HCV infection (van der Meulen et al. 2016, p. 6). While these initiatives are a step in the right direction, prison-based needle and syringe programs (PNSPs), which are essential for harm reduction in prisons, are scarce. Globally, WHO has been recommending as early as 1993, in conjunction with UNAIDS and other national and international organizations, that clean injection equipment be provided both in prisons and on release. The Office of the United Nations High Commissioner for Human Rights and UNAIDS (2006) have also provided explicit guidelines that prison authorities should introduce clean injection equipment as a means to prevent and control HIV transmission among incarcerated individuals. WHO guidelines (2009) state that when prison authorities receive evidence of injection drug use in prisons, "they should introduce needle and syringe programs, regardless of the current prevalence of HIV infection" (p. 103). In reviewing assessments of such programs in prisons,<sup>4</sup> WHO (2009) reported that they:

- ▶ do not endanger staff or threaten prisoner safety
- ▶ provide a safer and healthier environment for incarcerated individuals to live and work in
- ▶ do not increase rates of injecting or consuming drugs
- ▶ reduce the transmission of HIV and HCV
- ▶ reduce risk behaviors related to blood-borne diseases
- ▶ drastically reduce drug overdoses while increasing referral rates to drug treatment programs
- ▶ improve health outcomes for incarcerated individuals.

Analyzing the evidence from two pilot studies in Spain, WHO (2009) reported positive results from PNSPs. Noting their feasibility and adaptability to prison conditions, it identified the following outcomes:

- ▶ a reduction in risky behaviours and injection practices among incarcerated individuals
- ▶ an increased uptake in drug treatment programs
- ▶ no increase in drug use (e.g., heroin, cocaine)

Given these results, authorities issued a directive to formally implement the program,

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<sup>4</sup> See Lines et al. (2006), Stöver and Nelles (2003), and WHO (2004).

which, as of 2005, is operating in 33 prisons across the country (WHO, 2009).

However, despite the growing evidence that prisons can successfully introduce harm reduction strategies with positive outcomes,<sup>5</sup> fears remain that such measures “send the ‘wrong message’ and make [illegal] drugs more socially acceptable” (WHO, 2009, p. 104). While from this point of view acknowledging the reality of prison drug use is equivalent to admitting failure, doing so is nonetheless critical to addressing the greater problem at hand: that denying incarcerated individuals access to safe injection equipment also brings with it a public health concern.

In Canada, a lack of access to safe injection supplies means that incarcerated individuals are at greater risk of HIV and HCV infection and, with the lack of PNSPs, most federally incarcerated individuals bring any illnesses contracted while in prison back home to their communities when they return.

In the wider community, needle and syringe exchange programs are proven to be the most effective way of reducing the HIV transmission that occurs through sharing injection supplies. Given the serious threats of HIV and other blood-borne diseases, such harm reduction programs are therefore important for protecting public health.

There is substantial empirical evidence to support the public health and safety benefits of harm reduction strategies. Needle distribution and recovery programs have been shown to be safe, effective and less costly while reducing HIV risk behaviours and increasing access to health and social services for people who use injection drugs. For those in prison, PNSPs provide access to the same health services. They also make workplaces safer for prison staff by reducing the likelihood of accidental injuries from shared, non-sterile injection equipment (Canadian HIV/AIDS Legal Network, 2016).

Nurses are often the first point of contact for health care, especially those populations vulnerable to substance use across a variety of settings, including prisons. The high reported rates of drug use and communicable diseases such as HIV and HCV among prison populations, both in Canada and around the world, need to be addressed. Harm reduction, delivered through needle and syringe exchange programs, is an effective and pragmatic public health approach to caring for people who use drugs, including incarcerated individuals. Despite controversy and opposing views, the extensive research on harm reduction indicates that there are a number of benefits for prison populations, prison staff and communities at large.

Nurses and other health-care professionals have an ethical responsibility to provide non-judgmental care to individuals affected by the harms of illegal drug use regardless of setting. The values of harm reduction align with the primary values in the CNA Code

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<sup>5</sup> For example, in Belarus, Germany, Kyrgyzstan, Luxembourg, the Republic of Moldova, Scotland, Spain and Switzerland.

of *Ethics for Registered Nurses*, which guides ethical nursing practice while emphasizing human rights and the importance of treating all individuals with respect and dignity.

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