

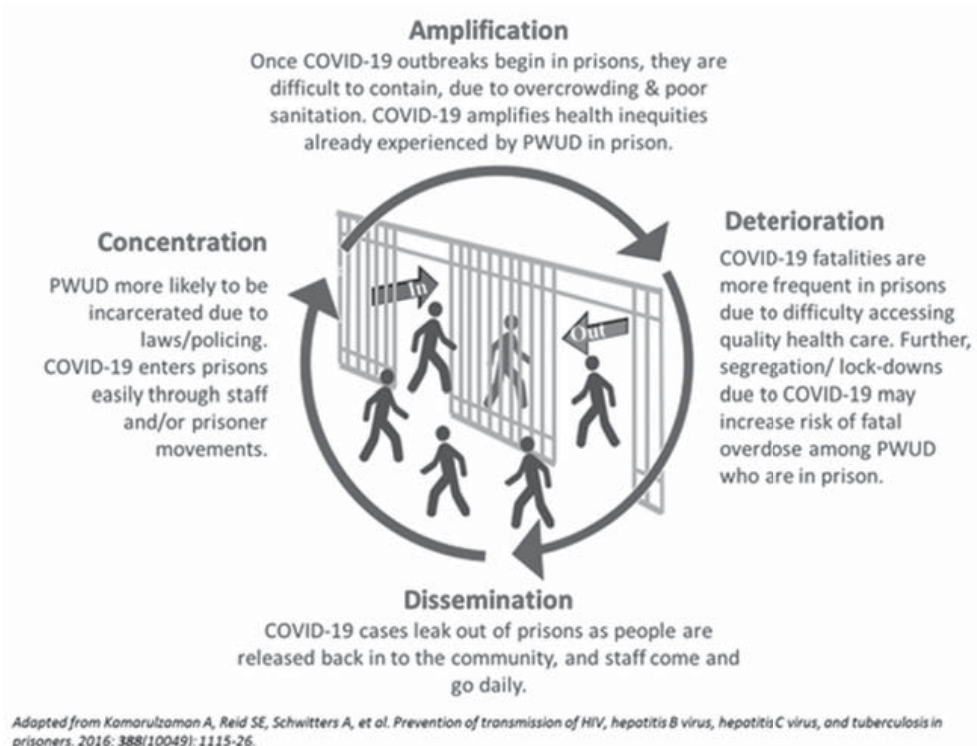
# **The Need for Evidence-Based Harm Reduction Services in Correctional Facilities During the COVID-19 Pandemic**

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## **INTRODUCTION**

Severe Acute Respiratory Syndrome Corona Virus 2 (SARS-CoV-2), the causative agent of COVID-19, is disrupting the physical health, economic, and psychosocial wellbeing of people globally, from all backgrounds (CDC, 2020). Although the pandemic has impacted all individuals to some extent, it has especially exacerbated the negative health outcomes experienced by marginalized populations, such as people who use drugs (PWUD). This group were already experiencing multiple public health emergencies prior to the COVID-19 pandemic, such as the on-going HIV pandemic and the overdose crisis, and PWUD continue to be at higher risk of poor health due to pre-existing health and social inequalities, such as high incidence of blood-borne pathogens like Hepatitis C virus (HCV) or injection-related infections. Despite evidence supporting the decriminalization of all drugs having existed for many years, certain substances still remain criminalized; leading to sustained high rates of PWUD in correctional facilities (van der Meulen, 2017). Correctional facilities experience issues of overcrowding, insufficient access to healthcare, poor sanitary services, and inadequate air circulation. Moreover, frequent transportation of prisoners in and out and between facilities hinders infection prevention efforts and provision of access to basic health care services (Harm Reduction International, 2018). These issues existed prior to the COVID-19 pandemic and have persisted despite it. In this commentary, we detail evidence that suggests providing simple harm reduction strategies to PWUD while they are incarcerated could result in reducing the spread of COVID-19 within correctional facilities, as well as mitigate the unintended harms and consequences of policies to reduce COVID-19 transmission in prisons, such as extended lockdowns and periods in segregation for medical quarantine. Prison health is public health; therefore, limiting the spread of COVID-19 within correctional settings could also lead to reductions in transmission of COVID-19 in the general public (see the figure below).



The theoretical framework for concentration of COVID-19 in prisons and increase in harm to People Who Use Drugs as a result of this. This framework suggests that interventions to reduce history is replete with examples of the deplorable conditions in correctional facilities that make prisoners vulnerable to the spread of infectious disease (Burki, 2020; Hawks et al., 2020). For instance, a physician described three different influenza outbreaks in April, October, and November 1918 in San Quentin State Prison (Stanley, 1919) in what would later be known as the “Spanish Flu”, one of the world’s deadliest public-health emergencies (Morens and Fauci, 2007). Yet even amid public health advancements in modern times, recommendations to prevent the spread of COVID-19 (e.g. physical distancing, handwashing, regular environmental cleaning, good ventilation, and mask use) (BCCDC, 2020) are rendered nearly impossible in correctional settings. Correctional facilities and prisoners, many of which are incarcerated PWUD, have been neglected in the global public health response to COVID-19. According to the New York Times database, as of 1 January 2021 in the United States, of the approximately 1.2 million prisoners, 480,000 prisoners had confirmed infection with COVID-19 and there were 2,100 deaths recorded (Derr et al.,

2021). This proportion of people in prison infected with COVID-19 in the US is between 2-40 times higher than in the general public (Bajema et al., 2020), suggesting that prisoners are facing vastly higher risks of acquiring this infection, and when they do acquire it, they may not be receiving appropriate or timely healthcare services.

### **PROBLEM 1: LACK OF ADEQUATE HEALTHCARE**

The health needs of prisoners are diverse. They typically experience elevated rates of health concerns including mental illness, infection, and pain. Chronic diseases are also increased among prisoners (Kouyoumdjian et al., 2016), which further elevates their risk of significant negative health effects related to COVID-19 illness (Akiyama et al., 2020). Prisoners have an increased prevalence of bloodborne pathogens, such as HIV and HCV (Akiyami J.M., et al., 2020), and are also disproportionately affected by various forms of mental illnesses, including substance use disorder (SUD). From a human rights and public health perspective, prisoners need to have equitable access to healthcare (McLeod and Martin, 2018). From a legal perspective, this is also essential, as it has also been mandated under the Mandela Rules and the Canadian Corrections and Conditional Release Act that prisoners must have the same access to health care to what is available in the community (Canada, 1992). The United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules) rule #24 (UNDOC, 2015) states: “The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status”.

### **PROBLEM 2: LACK OF HARM REDUCTION**

As PWUD frequently make up a large proportion of prisoners, access to opioid agonist therapy (OAT) (Malta, et al., 2020), needle and syringe programs (NSP), and naloxone in prisons is necessary to prevent harm associated with drug use, including death. Few North American prisons

offer harm reduction practices, despite evidence of existing innovative practices abroad, and of the complementary benefit of harm reduction practices to potentially reducing the transmission, morbidity, and mortality of COVID-19. Without access to safe using equipment, PWUD that are experiencing incarceration are forced to engage in risky behaviours such as sharing syringes and other equipment through which infections can spread, if they need to use drugs. There also is no ‘COVID-19 safe’ (e.g. physically distanced) way to share drugs or drug use supplies, therefore not only does sharing drug use equipment and drugs pose an HIV and HCV transmission risk, it is also potentially leading to COVID-19 transmission. While CSC has various NSP, they are punitive and must be more person centred to be safe and effective (van der Meulen et al., 2016). Anonymous access to safe using equipment through NSP within a correctional setting is a cost-effective way of reducing the transmission of HCV/HIV and injection-related infections such as endocarditis or skin and soft tissue infections (Assoumou et al., 2020). Without adequate access to safe using equipment PWUD will resort to reusing and inventing equipment based on what is available (Whitfield et al., 2020). With the already reduced capacity for access to timely healthcare in correctional facilities, early interventions such as NSP can reduce the burden of this overwhelmed system by reducing the number of complications related to drug use, as these facilities try and prevent the spread of COVID-19 among an aging population of prisoners.

### **PROBLEM 3: INADEQUATE SUPPLY OF OAT**

In many cases, healthcare policies within correctional facilities support maintaining existing OAT regimens, yet doses are not adjusted and OAT is not initiated for other people who would meet the criteria for opioid use disorder (OUD) (Bodkin et al., 2020). Inadequate access to harm reduction services risks creating an environment for substance diversion inside the facilities (CCSA, 2020). Smuggling of contraband, referred to as “packages”, is routinely seen in correctional facilities. The most common method of exchanging drugs within correctional facilities are either from “cheeking”, hiding prescribed medication in the mouth, or “plugging”, which refers to putting a package of drugs in the anus (O’Hagan and Hardwick, 2017, pp. 3-4). These practices increase the risk of COVID-19 transmission. If

prisoners had adequate access to OAT, harm reduction based NSP, and a pharmaceutical alternative to their drug of choice, there would be less need to smuggle drugs and contraband into the facility, thereby reducing COVID-19 transmission potential.

Without adequate treatment and management of substance use, prisoners that use drugs will resort to other means to manage their addiction and withdrawal (Casey et al., 2019).

Adequate provision of OAT could assist healthcare staff in the correctional facilities better identify new cases of COVID-19. Symptoms of opioid withdrawal include coughing, sneezing, vomiting, and other flu, and COVID-19 like symptoms, which may create confusion on suspected COVID-19 cases. Giving prisoners access to OAT also prevents unnecessary withdrawal in correctional facilities. Although OAT is considered standard of care for people with OUD (CRISM, 2017), there are still significant barriers to access such as stigma, waitlists, and restrictive/punitive policies (CSC, 2020). Given that incarceration typically results in periods of abstinence from drug use that decreases tolerance and increases the risk of overdose if the person returns to use (Binswanger et al., 2012), increasing coverage of OAT in prisons may also reduce the occurrence of opioid overdose.

#### **PROBLEM 4: POOR INFECTION CONTROL**

The introduction of COVID-19 into correctional facilities creates additional barriers to provision of adequate health care for other concerns, including blood-borne infections. Prisoners, especially those who are PWUD, are at an increased risk of being affected by diseases such as HIV, HCV, and tuberculosis, with HCV being the most prevalent. Untreated blood-borne pathogens, such as HCV, can lead to liver damage and other negative health outcomes, which has been seen to cause worsening COVID-19 illness in preliminary studies (Odjidja, 2020). COVID-19 has led to fewer people in prison receiving care for these diseases, both due to extended lockdowns preventing ‘non-essential’ health care visits, and increased demands on staff diverting them from non-COVID-19 work. Many barriers to adequate management of bloodborne pathogens in correctional facilities were identified prior to COVID-19 (Crowley et al., 2018; Farley et al., 2005), and the pandemic has exacerbated them. The poor management of diseases

like HCV and HIV in prisons prior to COVID-19 may be leading to higher COVID-19 morbidity and mortality among prisoners. Therefore, to reduce COVID-19 mortality among prisoners, HCV and HIV must be addressed.

## **HARM REDUCTION PRACTICES CAN BE A SOLUTION TO THESE PROBLEMS**

Several federal correctional facilities in Canada have adopted harm reduction practices such as NSP, allowing access to sterile injecting equipment, however, CSC policies restrict who can access these services (CSC, 2018). Though there is limited publicly available data, CSC implemented the first Overdose Prevention Site at Drumheller, Alberta in a federal correctional facility (CSC, 2019). These are positive steps that may mitigate some of the harms caused by COVID-19 to PWUD in prison. Provincial correctional facilities across Canada are significantly behind the federal system in innovating and implementing harm reduction services though. There should be no differences between provincial and federal as a large majority of prisoners must travel between a provincial correctional facility to a federal correctional facility. While it is likely that harm reduction strategies would need to be tailored to the individual correctional facility, they should still be consistently available in every facility, in any province, provincial or federal.

Several European countries have embraced a more person-centred harm reduction approach including the provision of anonymous vending machines to enhance access to safe drug using equipment (Sander et al., 2016) in prisons. By having anonymous vending machines for people to access safe drug use supplies, it not only provides prisoners with the autonomy and agency of their healthcare, it also is a way to reduce unnecessary contact between prisoners that are PWUD and guards or healthcare workers, reducing opportunity for COVID-19 transmission. These models show that there are non-punitive alternatives for correctional facilities to implement harm reduction practices in the age of COVID-19 and beyond.

Harm reduction pioneers in Atlantic Canada are in the beginning stages of leading the change with a novel nasal spray naloxone program available on the units in the facility. Nasal spray naloxone is generally not preferred by PWUD, and due to the spray being in an aerosol form, there is some concern of potential COVID-19 exposure. Nonetheless, we believe acutely saving a prisoner's life should be the priority in such situation. This novel



pilot program has made large advancements, however, it is still in the pre-implementation phase as it works through the large structural barriers of the justice system. While other provinces already have take-home naloxone programs in provincial corrections, these do not reduce the risk of overdose on the units. Due to COVID-19 lockdowns and increased time spent in segregation for medical isolation, more prisoners than ever may be using drugs alone. This means it is more important than ever to adopt facility-based changes such as having naloxone available on living units.

## CONCLUSION

Correctional facilities are obligated to protect prisoners that are detained in their facility. Despite this legal obligation, health, and social inequities continue to persist within prisoner populations, as the COVID-19 pandemic revealed (Yang and Thompson, 2020). Amid outbreaks across North American correctional facilities, harm reduction and preventative interventions are needed to reduce the morbidities and deaths experienced by prisoners. Prisoners are people too, and they deserve the same access to COVID-19 testing, treatment, and vaccines as the rest of the population. This pandemic highlights the intersection between substance use, incarceration, and risk of COVID-19 transmission, and presents the opportunity for change across multiple sectors that, if seized, could continue to be beneficial beyond COVID-19. By implementing harm reduction services, correctional facilities can increase access to healthcare interventions, social, and engagement programs for prisoners transitioning back into the community. Everyone deserves the right to adequate health care, and we must continue to advocate for change within our correctional facilities and in society at large.

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## CONFLICTS OF INTEREST

Matthew Bonn reports personal fees from AbbVie and grants and personal fees from Gilead Sciences, outside of the submitted work. Sofia Bartlett is an (unpaid) Executive Director of the Papua New Guinean and Australian registered charity Grass Skirt Project Inc. She has participated in Advisory Board Programs and received speakers' honorarium from Gilead Sciences and AbbVie, outside of the submitted work (all personal fees given as unrestricted donations to the British Columbia Centre for Disease Control Foundation for Public Health). Holly Richards and Kate Harland report no conflicts of interest.

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