Position Statement on Access to Opioid Agonist Treatment in Detention

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College of Family Physicians of Canada
Addictions Medicine and Prison Health Member Interest Groups

The Opioid Overdose Crisis

More than 11,000 Canadians have died from an accidental opioid overdose since 2016.[1] Opioid use disorder and non-medical opioid use are associated with other detrimental health outcomes including non-fatal overdose, neonatal abstinence syndrome, social disruption, and injection drug use and its associated harms.[2–4] The complex nature of the opioid overdose crisis requires a multi-faceted, cross-sectoral response. Part of this response must include interventions in the Canadian correctional system.

There is a relationship between opioid use disorder and non-medical opioid use and the involvement with the criminal justice system. Because most drug use is illegal in Canada, many people who use drugs are imprisoned. The majority of street-involved people who use illicit opioids have a history of involvement with the criminal justice system.[4] Rates of substance use and substance use disorders are higher for people who experience incarceration, and people continue to use substances while incarcerated.[5,6] Fatal opioid overdose is associated with a recent history of imprisonment.[7,8] In this context, it is critical that effective interventions aimed at reducing the harms associated with non-medical opioid use are widely available.

Opioid Agonist Treatment

Opioid agonist treatment (OAT) uses fixed, regular dosing of a long-acting opioid agonist medication to reduce symptoms of opioid withdrawal and craving as part of treatment for opioid use disorder. Canadian guidelines for treating opioid use disorder recommend OAT as first-line therapy.[9] The World Health Organization guidelines for treating opioid use disorder state that OAT should be available to people in prison and be equivalent to community treatment options.[10] Methadone and buprenorphine are the most commonly prescribed OATs in Canada, and slow release oral morphine is a third-line option.

OAT confers significant opioid-related and all cause mortality benefit for people with opioid use disorder.[11] OAT in correctional facilities is an effective intervention to reduce injection drug use and prevent transmission of blood-borne infections, and is associated with reduced post-incarceration mortality and opioid use.[12–15] From a societal perspective OAT is associated with earlier release from detention and lower rates of re-offending.[16,17]

Access to Opioid Agonist Treatment in Canadian Correctional Facilities

Access to OAT in Canadian correctional facilities varies widely and is often worse than access to OAT in the community. Policies in some jurisdictions endorse the delivery of OAT in prison; however, without adequate resources access remains limited. There are gaps in initiating

treatment, maintaining treatment, and continuity of treatment upon admission and release, and differences between provincial, territorial, and federal facilities.[18–21]

Family physicians are health advocates who are called on to be socially accountable.[22,23] The College of Family Physicians of Canada (CFPC) promotes social justice as the pursuit and/or attainment of equity in society.[24] Social justice focuses on addressing the social determinants of health and minimizing their negative effects on individuals' health.[25,26] Accordingly, the CFPC Prison Health and Addictions Medicine Member Interest Groups advocate for best health care practices for people who experience incarceration and people who use drugs in Canada.[27,28]

Therefore, the purpose of this CFPC position paper is to advocate for access to the same evidence-based therapy available in the community and to recommend that OAT be initiated and maintained for all appropriate candidates at provincial, territorial, and federal correctional facilities.

Recommendations

1. All people in detention who meet criteria for evidence-based OAT (including methadone, buprenorphine-naloxone, and slow release oral morphine) and who consent to receiving treatment should have access to opioid agonist therapy without delay.
2. All people receiving OAT in the community should continue, without interruption, an appropriate OAT upon admission to detention.
3. Anyone receiving OAT in detention should be connected to community-based addiction treatment to ensure uninterrupted continuity of care on release. Preparations for this transition should be started well before the release date so all partners are aware and the transition is seamless.
4. OAT should be used as one of a suite of evidence-informed interventions to engage patients in the opioid use disorder cascade of care, and to reduce or eliminate opioid-related morbidity and mortality in people who experience incarceration.

Conclusion

Health care standards in Canadian prison settings must achieve and maintain levels that at least meet the standards of medical care available to all Canadians. OAT is the standard of care for opioid use disorder, and is available in communities across Canada. To respect the dignity and human rights of people in prison, and as part of an effective public health response to the opioid overdose crisis, OAT should be widely available to people in detention across Canada.

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