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Increased access to opioid substitution treatment in prisons is needed to ensure equivalence of care

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The principle of equivalence of care holds that prisoners must be able to access health care of the same standard to that available in the community. We examined whether the principle of equivalence was met in New South Wales (NSW) in relation to opioid substitution treatment (OST). OST is an effective treatment for heroin dependence that is available in both community and prison settings in NSW.

In 2005, there were approximately 24,300 dependent heroin users in NSW (calculated by applying trend estimates of the number of injecting drug users in Australia from 2000-05[1] to the estimated number of dependent heroin users in NSW in 2000[2]), of whom 14,822 (61%) were enrolled in OST in community settings.[3] There were an estimated 3,146 regular heroin users in prisons in NSW in 2005 (calculated by applying the prevalenc

of regular heroin use prior to imprisonment in surveyed inmates[4] to the 2005 average full-time custody population of 9,101). Of these 1,680 (53%) were in OST.[3] Heroin users in the community have greater access to OST than those in prison (OR=1.4, 95% CI 1.3-1.5).

It would appear that equivalence of care in relation to OST is not yet being met in NSW. In order for access to OST in prison to be equal to the community, an additional 239 OST places are needed. This would cost approximately $3,500 per person per year,[5] but would provide considerable benefits. A follow-up of a randomised controlled trial of methadone maintenance treatment in NSW prisons found those in treatment for periods of at least eight months had a re-incarceration rate of 23 per 100 person-years, compared with 97 per 100 person-years for periods of no treatment.[6] Given the average cost of incarceration per inmate per year in NSW is $69,237,[7] the costs of providing additional OST places are minimal compared with the savings.

A case can also be made for the expansion of community OST programs. Waiting lists are a significant barrier to treatment entry for opioid-dependent patients.[8] Providing a surfeit of community OST places would be associated with increased costs in providing OST, but these would be offset by reduced criminal activity and improved general health of treated patients. Any expansion in community OST programs would ideally be accompanied by a proportional increase in prison OST places.

Balancing costs and benefits, expansion of prison OST programs to ensure equivalence of access to community OST is justified. Further expansion of community OST programs, with parallel increases in prison OST places, should also occur.

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