

PATIENT MOTIVATIONS, PERCEPTIONS AND EXPERIENCES OF OPIOID SUBSTITUTION THERAPY IN PRISON

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EXECUTIVE SUMMARY

People with opioid dependence are overrepresented in correctional settings (AIHW, 2013; Indig et al., 2010). Opioid substitution therapy (OST) is an effective treatment for opioid dependence, reducing illicit opioid use (Mattick, Breen, Kimber, & Davoli, 2009, 2014) and mortality (Degenhardt et al., 2011). OST is provided in correctional settings in many jurisdictions around the world (HRI, 2014), but there has been limited examination of the patient experience of opioid substitution therapy (OST) in correctional settings. Unexplored issues include reasons for entering (or not entering) treatment; patient perceptions of advantages and disadvantages of OST in prison; and preferences to cease or remain in treatment on release from prison. This latter issue is of particular importance, as clinicians report that patients often wish to cease OST prior to release, even when informed of the risk of overdose and benefits of remaining in treatment.

This qualitative study aimed to examine patient motivations for, and perceptions and experiences of, OST in prisons in New South Wales (NSW), Australia. Forty-seven participants were recruited from seven correctional centres across NSW between September 2012 and October 2013. All participants had a recorded history of opioid use and/or dependence. To ensure a broad range of perspectives were obtained, participants were selected on the basis of specific exposures to OST:

- **Exposure group A** (n=7): New inductions to OST. These individuals were within 28 days of commencing OST at the time of interview. They may have been in OST previously, in community or custodial settings;
- **Exposure group B** (n=11): Continuing OST from the community. This group of patients had been in OST prior to custody, and were in treatment in custody for at least 28 days before interview (i.e. had some familiarity with the opioid treatment program in prison).
- **Exposure group C** (n=10): Commenced OST in custody. These participants were in treatment for at least 28 days before interview (i.e. had some familiarity with the opioid treatment program in prison).
- **Exposure group D** (n=9): Voluntarily ceased OST in custody.
- **Exposure group E** (n=10): Patients who reported heroin use on reception to prison, but have not entered OST or have declined to be placed on the OST waiting list during this custodial sentence.

The sample was predominantly male (n=32; 68%), and 18 participants (38%) identified as Aboriginal and/or Torres Strait Islander. The average age of participants was 35 years. Three-quarters (n=35, 75%) of the sample were sentenced, 11 were on remand, and one participant was unsure of sentencing status. The majority (n=42; 89%) reported a previous incarceration history. Twenty-eight participants were currently prescribed OST (methadone n=27, 57%; buprenorphine-naloxone-naloxone n=1, 2%).

Findings by exposure group

Among new OST inductions (Group A, n=7), reasons for commencing OST included wanting to abstain from drug use in prison and in the community upon release, as well as to aid with opioid withdrawal. Some participants noted the role of OST in the management of chronic pain. Benefits of OST identified by this group included elimination of opioid cravings, and the financial advantages of not buying drugs in prison. Criticisms of the opioid treatment program reported by this group included the waiting period to enter the program, with over half reporting drug use during this period in order to manage withdrawal symptoms. All participants in this group reported a willingness to stay in OST post-release, with two participants noting that they would prefer to be switched from methadone to buprenorphine

formulations due to the lower frequency of administration (every second day) and higher number of 'take-away' doses available, which was deemed more practical for meeting employment commitments.

Almost all (10/11) Group B patients (continuing OST from the community) were satisfied to remain in OST. Most (7/11) were willing to continue with OST post-release, so as to avoid drug relapse. As in Group A, two participants reported a preference to switch from methadone to buprenorphine-naloxone formulations post-release. For those who were wanting to cease treatment prior to release, reasons for this included pressure from family members and friends, the stigma attached to OST, the long-term nature of OST, and the perceived side-effects of poor dental health and appearing 'stoned'.

Group C (n=10) were current OST patients who had commenced OST during this custodial period. Participants in this group reported drug use and unsafe injecting practices while in prison before commencing treatment. Most (6/10) reported that they would remain in OST post-release, at least until they felt they were stable and had a daily routine in the community. Those who wanted to cease treatment prior to release reported that they were primarily on OST for the management of their chronic pain and that on their release, they would seek other medication, often the preferred opioid analgesic they were prescribed prior to custody.

Group D (n=9) had ceased OST during their current incarceration period. Around half (4/9) of participants in this group expressed interest in re-starting OST. Motivations for restarting OST included wanting to cease drug use in prison, and prevention of opioid withdrawal. Again, it was reported that drug use and unsafe injecting practices occurred during waiting periods to enrol in treatment. Reasons for ceasing OST related to release from prison and a reluctance to continue in OST due to the long-term nature of treatment, daily stressors of obtaining methadone in the community, and previous unsuccessful attempts OST episodes in the community.

Group E (n=10) were people with a history of opioid use and/or dependence who had not entered OST in this period of incarceration. Seven participants in this group reported prior OST in the community or during previous incarcerations. Six of the ten participants in this group reported that they would like to be in OST, preferably prescribed a buprenorphine-naloxone formulation.

Recurrent themes across groups

Perceptions of opioid treatment program operation

Participants were critical of the time taken to be assessed for OST and commenced on treatment. Participants perceived that this process was expedited if they reported drug use in prison to health centre staff; however, drug use is not a high priority indication for treatment entry *per se* (unlike pregnancy or HIV seropositivity, for example), so it is unclear if this perception was valid. Once treatment had commenced, participants perceived that there was a lack of monitoring and limited discussion of long-term treatment plans, particularly in relation to ceasing OST.

Some participants questioned the motivations of other OST patients; for example, people with no recent history of opioid use who requested assessment for the opioid treatment program, or patients who deliberately requested higher doses of medicine than necessary in order to feel intoxicated.

Intentions to cease OST prior to or on release

Around one-third of current OST patients reported an intention to cease OST prior to or on release from prison. Participants identified aspects of OST in the community that they perceived as restrictive (e.g. daily dosing; difficulties in travelling to clinics within opening hours; difficulties going away from home). Some participants expressed concern that attending an OST clinic would result in drug use and/or crime as a result of exposure to past associates. Participants also expressed concern about the long-term nature of OST, with the perception that OST was replacing one addiction for another and in conflict with the goal of

being 'drug free'. Participants also identified the stigma attached to OST as a reason for ceasing treatment prior to release. For some participants, this issue was framed in terms of where best to withdraw from OST, specifically methadone – in custody, or in the community. These participants identified the prison setting as a more fitting environment for managing withdrawal.

Drug use in prison, including buprenorphine-naloxone diversion

Across groups there was consensus that drugs including cannabis, heroin, methamphetamine, and buprenorphine-naloxone diverted from the opioid treatment program. Availability and pricing of drugs varied by prison.

Drugs were injected and smoked. Awareness of the risk of blood borne virus transmission via sharing of needles and syringes was high, with specific mentions of risk of hepatitis C virus (HCV) and HIV transmission. Participants reported use of needles and syringes by multiple people despite these risks.

The issue of buprenorphine-naloxone diversion from the opioid treatment program was mentioned by 18 participants. Diversion appeared to occur largely in the context of patients being 'stood over'; that is, being forced to give their buprenorphine-naloxone to someone else. Participants reported that people engaged in stand over behaviour to obtain buprenorphine-naloxone for their own use (medicating withdrawal symptoms, or getting intoxicated) or to sell for profit.

Use of OST for chronic pain

Five participants were prescribed methadone for the treatment of chronic pain. Participants generally stated a preference for other analgesic medicines. Methadone was, however, perceived as more effective for pain relief than other options available in the prison setting (e.g. ibuprofen).

Naltrexone for the treatment of opioid dependence

Over half of participants (27/47) had heard of naltrexone (either oral or implant formulation). There was some scepticism regarding the utility of naltrexone treatment for opioid dependence in the prison settings, primarily because participants believed that those prescribed naltrexone would continue to use, or commence using, non-opioid drugs.

Discussion and conclusions

Treatment seeking was often precipitated by drug use and injecting in prison. OST was also sought to medicate opioid withdrawal symptoms. Keeping prison-based OST numbers within a range that results in safe management both in custody and upon release to the community has led to delays in accessing OST for those patients seeking to commence treatment in prison, and patients clearly have strong negative views about this approach. Among some participants, the waiting list appeared to act as a barrier to initiating the process of commencing OST. Balancing the needs of opioid dependent patients against operational and capacity issues, and safety and security concerns, are ongoing challenges for clinical staff. With some exceptions, benefits of OST in prison were largely framed in terms of avoiding negative experiences or outcomes, rather than as direct positive benefits of treatment. These findings highlight that although OST is perceived as preventing negative outcomes, it is not necessarily seen as producing positive outcomes for the individual, such as better health or quality of life. This is line with previous research that has reported the considerable ambivalence that many opioid dependent persons have towards OST (Harris & Rhodes, 2013).

Diversion of buprenorphine-naloxone from the opioid treatment program appeared to most commonly occur in the context of patients being 'stood over' for their medicine, although there may also be patients who voluntarily engage in diversion. The potential for diversion of buprenorphine products used for OST in correctional settings has been previously identified (Gordon et al., 2014; Kinlock, Gordon, Schwartz, & Fitzgerald, 2010; Magura et al., 2009), and the combination buprenorphine-naloxone film was introduced into NSW correctional

centres specifically in response to concerns regarding diversion of the mono-buprenorphine formulation (administered sublingually). Policies and procedures for reducing the incidence of diversion and for responding to identified cases of diversion are in place in correctional health centres in NSW.

Despite the identified benefits of OST in prison, there was considerable ambivalence among patients regarding continuation of OST once released. Balancing the preference of many patients to cease OST prior to release against patient safety post-release is a substantial challenge for correctional health care providers. The weeks immediately after release from prison are associated with an elevated risk of drug-related death (compared to other time at liberty) (Merrall et al., 2010), and exposure to OST during this period is highly protective against mortality (Degenhardt et al., 2014). As such, correctional health care providers in NSW are trained to advise patients to remain in OST through their transition to the community, and are reluctant to assent to patient requests to cease OST prior to release. This tension between patient preference and evidence-informed clinical practice appears to be perceived by patients as a lack of consultation and/or poor treatment planning. Further work is needed examining provider perspectives of OST in prison, and determining models of care to enhance post-release engagement in OST.

Participants reported that injecting drug use occurred in prisons. Awareness of the potential for HCV or HIV transmission through the sharing of injecting equipment was high; nonetheless, participants reported that sharing of needles and syringes was common. Participants perceived a needle and syringe program as feasible for the prevention of re-use of injecting equipment.

This study has generated unique data on patient perspectives of OST in correctional settings. We have described patient perspectives on entry to, experiences of, and retention in, OST in prison and post-release. Our findings have highlighted the challenges facing opioid treatment providers in prison in addressing patient ambivalence towards OST and preferences to cease OST prior to release, and can inform the development of policies and clinical practices that are mindful of patient perspectives and concerns. These results are suggestive of the need for further work examining how best to attract and retain opioid dependent prisoners in treatment, including provider perspectives; evaluation of programs designed to increase post-release retention in OST (and other care), and quantitative analyses of retention in OST in prison and post-release.

1. INTRODUCTION

Opioid substitution therapy (OST) is the regular administration of opioid agonists (e.g. methadone) or partial agonists (e.g. buprenorphine, combined buprenorphine-naloxone) for the treatment of opioid dependence (WHO, 2009). OST is the most commonly provided treatment for heroin dependence in Australia (Ritter & Chalmers, 2009). OST using methadone or buprenorphine (including buprenorphine-naloxone) is effective in reducing illicit opioid use and injecting drug use (Mattick et al., 2009, 2014), as well as associated harms including HIV and hepatitis C virus (HCV) infection (MacArthur et al., 2014), criminal activity (Lind, Chen, Weatherburn, & Mattick, 2005), and mortality (Degenhardt et al., 2011).

OST is offered in prisons in all Australian states and territories, albeit on a limited basis in some jurisdictions (Rodas, Bode, & Dolan, 2012). On a snapshot day in 2013, there were 30,775 prisoners in Australia (ABS, 2013), of whom 3,265 were in OST (AIHW, 2014). OST in prison reduces heroin use and injecting drug use (Dolan et al., 2003; Larney, 2010), and nearly eliminates unnatural deaths of opioid dependent people in custody (Larney et al., 2014). There are also significant benefits to be had from retaining OST patients in treatment as they transition from prison to the community. Compared to other time at liberty, the period immediately following release from prison is associated with a substantial increase in risk of fatal drug overdose (relative risk of death in weeks 1-2 compared to weeks 3-12: 3.1-8.4) (Merrall et al., 2010). However, opioid substitution therapy in the period immediately prior to release, and post-release, is associated with a substantial reduction in mortality in the weeks after release from prison. In a population cohort of incarcerated opioid dependent people in New South Wales, Australia, receipt of OST in prison with retention in treatment in the community was associated with a 75% reduction in post-release mortality risk (Degenhardt et al., 2014).

These findings suggest the critical importance of attracting opioid dependent people in prison into OST, and retaining them in treatment as they transition to the community. However, the process of attracting and retaining opioid dependent prisoners in OST is largely unexplored. It is possible that, in a prison setting, patient motivations for seeking OST and perceptions of OST are different from those seen in community settings. Constrained access to heroin while in prison may act to motivate some to enter treatment when they otherwise would not have, or time in prison may be seen as an opportunity to 'pilot test' OST (Koester, Anderson, & Hoffer, 1999). Remaining in OST long-term may not be the individual's goal. Health care providers in prison report that patients often wish to cease OST prior to release, despite advice to remain in treatment to mitigate post-release mortality risks. Balancing patient motivations and preferences with patient safety and good clinical practice is a major challenge for prison health care providers.

1.1 Aims

This study aimed to describe the patient experience of OST while incarcerated in NSW, Australia. Specifically, we aimed to examine:

- a. Patient motivations for entering/not entering OST, and staying in/ceasing OST;
- b. Patient perceptions of OST; and
- c. Patient experiences of benefits and difficulties associated with being on OST.

2. METHODS

We undertook a qualitative study of incarcerated people with a history of opioid use and/or dependence in New South Wales (NSW), Australia, to examine patient motivations for, perceptions of, and experiences of OST in prison.

2.1 Ethical approvals

This study was approved by the Justice Health & Forensic Mental Health Network Human Research Ethics Committee and the Corrective Services NSW Research Approval Committee.

2.2 Setting

This study was undertaken in NSW correctional centres. Health care in NSW correctional centres is provided by Justice Health and Forensic Mental Health Network (JH&FMHN), a statutory body under the NSW Ministry of Health. The opioid treatment program in NSW correctional centres is among the largest and oldest prison-based OST programs in the world. Patients eligible for OST are prescribed methadone or buprenorphine-naloxone. Patients requesting induction to OST are required to undergo a rigorous assessment of suitability for OST after completion of medically supervised withdrawal and wait until a treatment place becomes available before they can commence treatment. People on OST on reception into custody are continued on treatment following confirmation of their treatment program from their community prescriber, provided no contraindications are identified (e.g. the patient missed multiple days of dosing prior to incarceration and requires medical review before prescription can be continued).

2.3 Participants

Of the 59 participants who were approached to be interviewed, 80% (n=47) agreed to participate. Participants were recruited from seven NSW correctional centres in the greater Sydney area (see Appendix A for recruitment sites). Data collection occurred between September 2012 and October 2013.

In order to obtain a broad range of views, we identified five groups with different exposures to OST in the correctional setting, and aimed to recruit 10 participants per each of these various exposures (see also Figure 1):

- Exposure Group A (n=7): New inductions to OST. These individuals were within 28 days of commencing OST at the time of interview. They may have been in OST previously, in community or custodial settings;
- Exposure Group B (n=11): Continuing OST from the community. This group of patients had been in OST prior to custody, and were in treatment in custody for at least 28 days before interview (i.e. had some familiarity with the opioid treatment program in prison);
- Exposure Group C (n=10): Commenced OST in custody. These participants were in treatment for at least 28 days before interview (i.e. had some familiarity with the opioid treatment program in prison);
- Exposure Group D (n=9): Voluntarily ceased OST in custody; and

- Exposure Group E (n=10): Patients who reported heroin use on reception to prison, but have not entered OST or have declined to be placed on the OST waiting list during this custodial sentence.

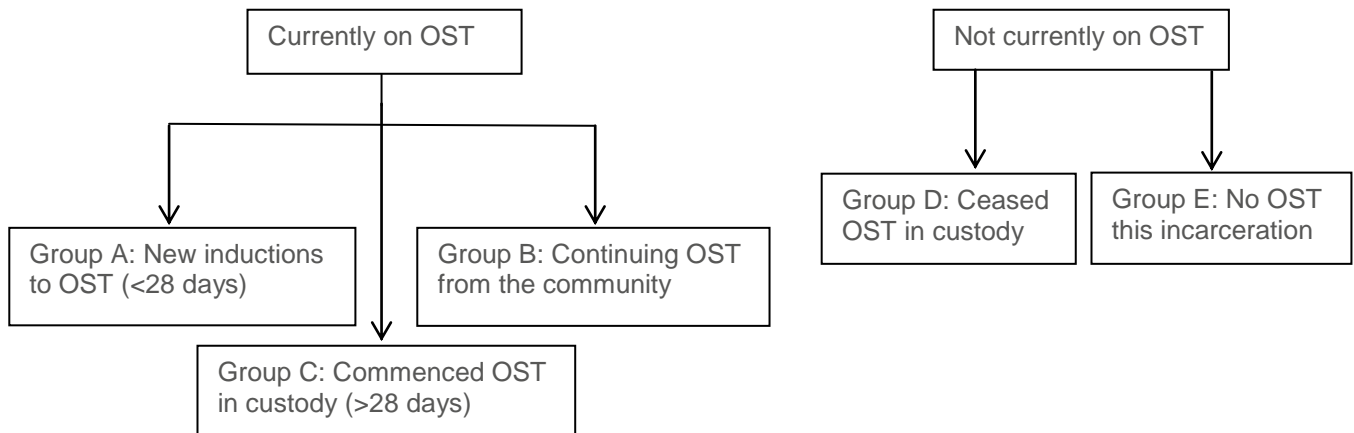


Figure 1: OST exposure among study participants

The recruitment process differed slightly for each group. New inductions to OST (group A) were identified through the JH&FMHN Drug and Alcohol Database. Participants in groups B, C and D were primarily identified through the Drug and Alcohol Database, along with referrals from JH&FMHN clinical nursing staff. Group E participants were recruited via the JH&FMHN reception health assessment, referrals from other Group E interviewees, and referrals from JH&FMHN clinic nursing staff. Given the difficulty in recruitment for this group, some participants were identified using the Drug and Alcohol Database by cross-referencing participants receiving treatment for HCV infection with those in current OST. Those in current OST were excluded and where possible, the remaining HCV treatment patients' files were examined to identify if heroin or other opioid use was reported at induction into custody.

2.4 Procedure

Written informed consent was obtained from all participants and confidentiality was assured (See Appendix B). A semi-structured face-to-face interview was administered to all participants, with questions tailored to the OST exposure of the groups (See Appendix C). The interview covered demographic characteristics, drug use, reasons for entering (or no entering) OST in prison, perceptions and experiences of OST in prison, and views on cessation of OST prior to or on release. Interviews were tape recorded and transcribed. Participants were compensated with a \$10 deposit to their buy-up account.

2.5 Analysis

Interviews were audio-taped and transcribed verbatim. Interview data were coded for key words and themes using NVIVO 10 (QSR International Pty Ltd, 2012). We employed an exploratory, inductive approach to coding (Braun & Clarke, 2006), without presupposing themes that might emerge. An iterative coding process was undertaken to firstly identify broad themes, then specific themes within these. The specific themes are described below, with quotes illustrating participants' perspectives.

3. RESULTS

3.1 Sample demographics

Of 47 participants, two-thirds (n= 32, 68%) were male, and 18 (38%) identified as Aboriginal and/or Torres Strait Islander. The average age of participants was 35 years (SD 9, range: 21-56 years). Three-quarters (n=35, 75%) of the sample were sentenced, 11 were on remand, and one participant was unsure of sentencing status. The majority (n=42, 89%) reported a previous prison history. Sixty percent (n=28) reported current engagement in OST (methadone n=27, 57%, buprenorphine-naloxone n=1, 2%) and 40% (n=19) were not on any OST.

We present first results by OST exposure group, followed by an analysis of themes that were identified across groups.

3.2 Group A: New inductions to OST

3.2.1 Demographics

Group A participants were about to or had recently (<28 days) commenced OST in prison. The group included seven participants (three male). The average age was 36 years (SD 11, range 22-56 years) and four identified as Aboriginal and/or Torres Strait Islander. Participants were from four metropolitan prisons; four were sentenced, two were on remand, and one participant was uncertain of their sentencing status. Six out of the seven had been to prison previously. All participants were currently prescribed methadone. See Appendix D for codes and demographics of participants.

3.2.2 Motivations for starting OST in prison

Five of the seven participants had self-referred for OST. The primary reasons for enrolment in the opioid treatment program included wanting to abstain from drug use in prison and in the community upon release, as well as to medicate withdrawal symptoms (A2, A5, A6, A7):

“Yeah, I can't wait to get out and have a shot. It's terrible, that's why I'm glad I'm on the methadone now, because I know that I'm going to be on a stable dose when I get out and I'm not going to want to go and get a shot, I'm just going to want to go home and get on with my life” (A2, 22 year old female).

Another issue, raised by four people in this group, was the use of OST for chronic pain management (A3, A4, A5, A6):

“Yeah, I only jumped off it when I come in. Probably two weeks, two and a half weeks, I got back on it because I was getting really bad back pain and I hadn't had it for months. But my back and my arms have been playing up a lot more. Yeah, my back pain has now gone, so it's good” (A4, 32 year old female).

Six of the seven participants (A2, A3, A4, A5, A6, A7) intended to remain on OST while in prison.

3.2.3 Perceived benefits of OST in prison

Most Group A participants reported physical and emotional benefits of OST in prison: *“it calms you down.... It relaxes you” (A3, 29 year old female), “it warms up your body [when hanging out/in withdrawal]” (A1, 30 year old female).* Other participants identified not having to “chase” (find and obtain) drugs in prison as a benefit of OST. Being able to abstain from drugs in prison led to perceived financial benefits (avoiding costly drug purchases), and health benefits (avoiding sharing of needles and syringes).

3.2.4 Criticisms of OST in prison

The waiting period to enter treatment was the most frequently mentioned criticism of the OST program, with self-reported waiting times ranging from one day to five months. Five of the seven participants (A1, A2, A3, A4, A7) reported having used drugs including heroin, buprenorphine (formulation uncertain) and cannabis while waiting for their OST program to commence:

A7: *I just used every day, two or three times a day....Yeah, bup or heroin [before being put on OST]*

Interviewer: *How are you taking it?*

A7: *IV, I ended up shooting up in my feet...Yeah, my (own) syringe. I don't share. I don't have Hep C... I was shooting into my feet because I've got nothing...I haven't used my arms for years. As you see, there's nothing there. Finally [Nurse] saw me here and then three and a half months after I saw her I got on the program. She said, "Are you shooting up?" I said, yeah, in my feet, actually. She said, "Oh, my God." I had to show her fresh track marks. (A7, 40 year old male).*

Another criticism of the OST program related to assessment and supervision of patients in OST. Participants suggested that there were patients receiving OST who were not opioid dependent. Furthermore, some participants felt that doses were not adequate, and there was a lack of supervision and consultation with the patient around long term plans to either continue or cease OST:

"...for instance if they think that girls don't need to go up (in dose) and they look stable and they're only going to go up just to get smashed..." (A2).

3.2.5 Intentions to cease OST prior to or on release

Six of these seven participants reported that they would prefer to stay on OST after their release. Of those, four reported that they would stay on methadone in the community for an undefined period, or until they felt they were "clean" (i.e. no longer felt cravings to use heroin):

Interviewer: *Any plans to get off it [methadone] before you leave?*

A2: *No, no 'cause I know I need to be on it. Until I'm strong enough to be able to not worry about any other drugs, I know that I have to stay on the methadone, and it's going to help me in a big way. It's going to have a big effect on my life.*

Two participants (A6, A7) reported that they were content to stay on the methadone program until their release however, upon their release they were looking to switch from methadone to a buprenorphine formulation. There was interest in the buprenorphine-naloxone film ("strips"), as this would allow them to receive more unsupervised doses and reduce the frequency of clinic attendance. One of these participants reported an intention to continue with buprenorphine for a finite period of six weeks after release.

3.2.6 Summary: Group A

Group A participants had recently (within 28 days) commenced OST in prison, for reasons including avoiding using drugs in prison, medicating opioid withdrawal, and chronic pain. Six of seven intended to remain in OST in prison. The main criticism of the opioid treatment program was the waiting period to start treatment. Other criticisms were a perceived lack of adequate assessment that allowed patients without opioid dependence to obtain OST, and the lack of longer-term planning for patients through their custodial sentence and to the

community. Most participants wanted to stay on OST on release; two participants wanted to switch to buprenorphine formulations of OST on release so as to obtain unsupervised doses and reduce the frequency of clinic attendance.

3.3 Group B: Continuing OST from the community

3.3.1 Demographics

Group B were current OST patients who had been on OST prior to reception in custody and had continued treatment in custody. There were 11 participants in group B, of whom six were male. The average age was 32 years (SD 8, range 23-50 years) and three identified as Aboriginal and/or Torres Strait Islander. Seven participants were sentenced, with four reporting being on remand; 10 of 11 had previously been incarcerated. Ten group B participants were prescribed methadone, and one buprenorphine-naloxone. See Appendix D for codes and demographics of participants.

3.3.2 Intentions to cease OST prior or on release

The majority of participants (10/11) reported that they were content with their current OST program. On being questioned of their intention to remain in OST on release, seven specifically reported that they would like to remain in OST, but reduce their dose, and five reported that they would like to have completed the OST program (“come off methadone”) prior to release (B1, B3, B4, B6, B8). Two participants reported wanting to transition to buprenorphine formulations of OST upon release (B4, B11).

The participants who preferred to continue OST post-release universally noted the potential for relapse to dependent opioid use if they ceased treatment (B2, B5, B7, B9, B10, B11):

B5: I'll probably come down to about 20 [mg of methadone] and then just get out on about 20. I don't think it would wise to jump off it.

Interviewer: Why is that?

B5: I've got too much stuff I've got to sort out, get out, and I don't know if I'm even going to have a proper address. I've got issues with DoCS. I don't want to put myself in the predicament where I'm using again (B5, 35 year old male).

Of those who wish to cease treatment prior to or at release, the following concerns were reported:

- Pressure from family and friends to cease OST (B1, B3, B4, B8, B11);
- The long-term nature of OST; knowing people who have been on OST for many years without ‘recovery’; and the stigma associated with methadone in particular (B1, B3, B8); and
- The perceived negative physical effects of being on OST (methadone); dental hygiene and feeling ‘stoned’ were mentioned (B1, B4, B11).

“I've been on it eight years. I guess ... I don't know, I find that I tend to sort of run into old friends, go and pick up at the clinic, and that's how I will start using again and I just want to, yeah, be done with it. You know, it's restricting. I can't go away, can't do a lot of things. Yeah, I've got two kids as well and when I do get my kids back, I don't want my kids knowing” (B3, 28 year old female).

The two participants who reported a preference to switch from methadone to buprenorphine formulations post-release identified methadone clinic hours and locations as barriers to employment (i.e. clinics were difficult to access as opening hours conflicted with work hours).

They also noted that obtaining takeaway doses of buprenorphine formulations was easier than obtaining takeaway doses of methadone (B4, B11).

3.3.3 Summary: Group B

Group B participants had been in OST prior to reception into custody and remained in treatment. Almost all patients in group B were content on their OST program (10/11). Over half (7/11) wanted to remain on OST post-release due to concerns about drug relapse. For those that reported a desire to cease OST on release, pressure from family and friends to cease treatment, the long-term nature of OST, the stigma attached to methadone, and perceived side-effects of methadone use on health and wellbeing (e.g. poor dental health) were the main reasons stated.

3.4 Group C: Commenced OST in custody

3.4.1 Demographics

Group C were current OST patients who had commenced OST during the current custodial period (>28 days previously). There were 10 participants in Group C, of whom seven were male. The average age was 37 years (SD 11, range 24-56 years), four identified as Aboriginal and/or Torres Strait Islander, and eight were sentenced (two on remand). Eight of ten participants reported that they had previously been incarcerated. All Group C participants were prescribed methadone. See Appendix D for codes and demographics of participants.

3.4.2 Entry into the OST program in prison

Among this group, the self-reported waiting period to commence OST ranged from two weeks (C1) to seven months (C9). All participants in Group C reported that their primary reason for commencing OST was that they had been using drugs while in custody. The majority of participants (8/10) reported that they intended on remaining on OST in prison.

3.4.3 Perceived benefits of OST in prison

Benefits of OST described by participants were conceptualized in terms of harms avoided by being in treatment, including the financial costs of drug use (C1, C5, C6, C10) and the physical risks of unsafe injecting practices (C3, C5, C6, C10).

“Yeah, I told them I was using nearly every day. Whenever I could get it I’d use it. I come in with heaps of it. I was using it whenever I could. Then I got on the methadone because I had to do the Hep C treatment because I caught Hep C” (C6, 28 year old male).¹

Management of chronic pain was also mentioned by several participants (C3,C4, C7, C8):

Interviewer: And it [methadone] seems to be holding you and working?

C8: It’s a hell of a lot better than fighting for Nurofen (laughs).

Interviewer: Yeah I bet.

C8: I mean it aches chronically, but yeah it’s a lot better than what it was....I mean there’s no other pain medication that I can really have here, they won’t give me anything else....Panadeine Forte makes me sick. (C8, 28 year old female)

¹ JH&FMHN patients with a recent history of opioid dependence who are receiving treatment for chronic HCV infection are encouraged to enter or remain in OST to reduce the risk of HCV re-infection through injecting drug use.

3.4.4 Criticisms of OST in prison

Half of Group C participants commented on the waiting period between assessment for suitability for OST and commencing treatment. It was the opinion of these participants that it was the waiting period that was leading to drug use in prison and, they speculated, the transmission of blood borne viruses (C1, C3, C3, C8, C9):

“They need to make it easier to get on [OST] than what they do for a lot of people because some people have been sitting on waiting lists for six months” (C1, 37 year old male).

“I’ve heard of blokes waiting six or eight months and I know there’s HIV and stuff like that always getting around the jail and I know it’s in [specific part of prison] now. How much at risk does the bloke got to put themselves to, you know, before someone will help them, sort of thing” (C3, 41 year old male).

“I think they’ve got to take this two month waiting list thing away. They have to. It’s - I’m telling you the Hep C rate and the AIDS rate is just going to skyrocket. You know I’ve seen like five plus girls use one fit at one sitting you know, let alone the rest of the stuff that happens. They get passed around their compound and it’s just a joke. You know it’s ‘cause girls are coming in and they’re sick you know” (C8, 28 year old female).

“No, the wait to get on it, yeah. I waited months even though I reported it every week that it was getting harder and harder for me and I was using a lot, and I had to wait literally months for it. Even though I was on it on the outside, I had a history of using methadone, and I still had to wait a very, very long time” (C9, 24 year old female).

Other criticisms included lack of supervision and discussion between staff and patients, particularly regarding requests to decrease their methadone dose or terminate their methadone treatment (C4, C7).

3.4.5 Intentions to cease OST prior to or on release

Six of ten Group C participants specifically reported that they intended to continue OST post-release (C1, C2, C3, C5, C6, C8). These participants noted the stability provided by OST when faced with the challenges of reintegrating into society (“seeing how things go”) (C1, C2, C3, C5, C6, C8).

“No, I’ll stay on it. Yeah, I think I’ll stay on it. If I know I’m getting out for sure I might start coming down. Then you get excited, I suppose. I think I’ll just stay on it until ... I’ll wait until I’m out in that environment where I can come down and start eating better and that” (C5, 53 year old male).

The remaining four participants in this group reported that they would like to have ceased OST before release (C4, C7, C9, C10). Two of these participants reported that they were prescribed methadone primarily for chronic pain relief, and that pain medication other than methadone would be more preferable on their return to the community (C4, C7).

Interviewer: What’s your thinking about being on methadone when you leave?

C4: No, I don’t want to be on it when I leave.

Interviewer: What were the main motivations behind that?

C4: Well, I just want to be straight. I just want to be normal. Yeah, I’m just over it.

Interviewer: So when you say you want to be straight, you want to be normal, how does methadone affect you then?

C4: *Well, really, to be honest, it doesn't do anything for me except get rid of the pain, which I haven't got anymore. I would have been off it over a year ago now but this program (Hepatitis C treatment) is the one that stopped me from finishing it.*

3.4.6 Summary: Group C

Group C consisted of participants who had commenced OST in prison and were currently in OST. All participants reported having enrolled in OST following drug use during their current custodial period. Specifically, enrolment in the program was driven by the financial and physical costs (unsafe injecting practices, withdrawal) of drug seeking and use in prison, as well as chronic pain management. Six out of the ten reported wanting to stay in OST post-release. Two participants receiving methadone for chronic pain management stated an intention to cease methadone and seek other pain medication on release.

3.5 Group D: Voluntarily ceased OST in custody

3.5.1 Demographics

Group D participants had previously been prescribed OST, but ceased treatment during this custodial episode. Only patients who voluntarily ceased treatment were included in this group. This group included nine participants, of whom eight were male. The average age was 35 years (SD 10, range 21-51) and four identified as Aboriginal and/or Torres Strait Islander. The majority had been sentenced (n=7) and the remainder reported being on remand (n=2). Eight of the nine participants had previously been incarcerated. See Appendix D for codes and demographics of participants.

3.5.2 Interest in re-engaging with the Opioid Treatment Program

There were mixed feelings in this group about being on OST in prison. Four participants expressed interest in re-engaging with the opioid treatment program (D2, D3, D6, D9). The remainder intended to continue their custodial period without OST (D1, D4, D5, D8, D10).

3.5.3 Perceived benefits of OST in prison

Benefits of being in OST included not having to use drugs in prison (D2, D4, D10), and prevention of opioid withdrawal symptoms (D2, D8).

3.5.4 Criticisms of OST in prison

Participants expressed concern regarding the waiting period between assessment for OST and commencing treatment. Linked to this was the issue of drug use in prison and sharing of injecting equipment (D2, D6, D10).

"Yeah, people that have got genuine problems with like heroin and that. Yeah, they need better access to at least the methadone program. I wouldn't say the bup program because I know it does cause a lot of problems in here but methadone for sure" (D10, 51 year old male).

D2: *Yeah, I've caught it [HCV].*

Interviewer: *Yeah, and did you get it from...?*

D2: *I caught it last year 'cause of the hold on the methadone program, yeah.*

Interviewer: *Right, so you shared [syringes] in jail?*

D2: *Yeah. (D2, 21 year old male)*

3.5.5 Reasons for ceasing OST in prison

When participants were asked why they had ceased OST, their reasons were primarily related to not wanting to be on OST when released from prison. Reasons for ceasing treatment were framed in relation to avoiding perceived negatives of OST in the community, such as the long-term nature of OST and daily clinic attendance (D4, D5, D8).

“And I was planning for when I do get released, I don’t want to have to go to a methadone clinic and be picking up every day and run into the old crowd and, you know, so it was mainly, yeah, just trying to start fresh and, you know, I didn’t feel that I needed it anymore so I didn’t need to be on it if I didn’t need it” (D8, 28 year old female).

3.5.6 Summary: Group D

Group D participants were those that had ceased OST in prison. Despite having voluntarily ceased OST, four of nine participants in this group reported a preference to re-engage with the opioid treatment program. Participants ceased OST in preparation for prison release.

3.6 Group E: No OST in current custodial episode

3.6.1 Demographics

Group E were individuals who reported heroin use on reception to prison, or were otherwise identified as having a history of heroin or other opioid use, but had not entered OST or had declined to be placed on the OST wait list during their current custodial sentence. The group comprised 10 participants; eight were male and all had been imprisoned previously. The average age was 36 years (SD 7, range 30-45 years), three identified as Aboriginal and/or Torres Strait Islander and eight had been sentenced. See Appendix D for codes and demographics of participants.

3.6.2 Previous OST episodes

Seven of ten participants in this group had previously been prescribed OST (E1, E3, E6, E7, E8, E9, E10), including three who were first prescribed OST in prison. Four participants had previously been prescribed methadone; one had previously been prescribed a buprenorphine formulation; and two had previously been prescribed both methadone and buprenorphine (formulation unknown).

3.6.3 Reasons for not entering OST in prison

Participants offered a variety of reasons for preferring not to be on OST in prison. Some participants described adverse physical effects during previous treatment episodes with methadone. The prospect of daily dosing was off-putting to some participants, and others described concerns about eventual methadone withdrawal:

“I just find it hard to hold the methadone down, yeah, and bad skin problems with it, for some reason” (E7, 37 year old male).

E1: *It just cramps your guts and stuff up, like yeah it’s just no good.*

Interviewer: *So like constipation, can’t go to the loo, that stuff?*

E1: *Yeah, constipation all that, year. It’s just worse, I reckon. It’s hard to get off too.*

“I just don’t want to have them handcuffs on me...just really, you’ve got no choice, you’ve got to wake up and go to the clinic every morning” (E3, 41 year old male).

"I didn't want to go through the drama of having to go get it every day, and just the stigma attached to it, and like when I thought about it, I did put in forms to go on methadone, but I haven't gone back to it because I've got friends that have been on it, and they're trying to get off, and it's, like, even my cellmate now, he's trying to get off it and he's down to a small dose and can't sleep at night, and – yeah, I just don't want to go through that" (E2, 35 year old male).

3.6.4 Barriers to OST in prison

Several participants noted an interest in OST, but were concerned that they would be required to wait for an unspecified period before commencing treatment. The waiting period appeared to be a significant barrier to treatment entry, as some participants reported that they did not bother seeking treatment, assuming they would be leaving prison before or shortly after commencing treatment:

Interviewer: And so did they ask if you wanted to go on the program?

E10: Oh you can't do it anymore, they don't put you on the program from here anymore. It takes months and months to do it. Usually what they'll do is offer it to you when you're about to leave. I've seen that happen a couple of times. (E10, 34 year old female).

3.6.5 Summary: Group E

Group E participants were those with a history of opioid use who had not entered OST in this custodial period. Participants reported various reasons for not entering OST in prison, including adverse side effects, the routine of daily dosing, and concerns about eventual withdrawal. The waiting period to commence treatment may be perceived by patients as a substantial barrier to treatment.

3.7 Recurrent themes across groups

3.7.1 Perceptions of Opioid Treatment Program operation

Participants were critical of the waiting time to be assessed for OST, and of the waiting time between assessment for OST and commencing treatment. Some participants reported that treatment entry could be expedited by reporting drug use in prison, but it should be noted that drug use or injecting is not a criteria *per se* for high priority or fast-tracked entry to OST under Justice Health and Forensic Mental Health Network guidelines (unlike, for example, pregnancy or HIV seropositivity). Once treatment had commenced, participants believed that there was a lack of monitoring of the patient and limited discussion of long-term treatment plans, particularly in relation to ceasing OST:

Interviewer: What's the relationship been like with your prescriber?

C5: He's all right. Yeah, he's good. I haven't seen him too much...

"But something too, like when you want to come off the methadone program and stuff and you're all for it, the clinic and doctors and nurses, they won't give you anything to help you get through it. Like maybe something that will stop the stomach cramps or something that will help you sleep or whatever, you know. Maybe they did in the past and too many people have ruined it for everybody else." (B11)

"Increasing your - going down, making some kind of - they don't make any long term plans for you in here. You know like I guess it's not really safe for girls to jump off just before they get out. I reckon probably at least - out of say 100% of people that do go off before they go out, they're only going down off it for stupid reasons. They're not putting everything into proper thought you know. A lot of them want to have their last dose before they walk out the gate, that's just setting them up to fail." (C8)

“Yeah, just from past experience with other guys, seeing what they had to do to come down, it’s sort of like anywhere between a fortnight to a month and a half before they get to speak to someone.” (B7)

Some participants questioned the motivations of individuals with no recent history of opioid use who requested to be assessed for OST. Some participants believed that some people prescribed OST deliberately sought doses higher than necessary to experience opioid intoxication.

“Yeah, yeah. I just - but they haven’t used for months and months and then all of a sudden they want to get on it. Obviously they’ve got to start asking themselves questions why they want to get on it. Some people want to get on it just to get smashed. I don’t know I think some - they need to be educated about it properly before they go making their decision. But I guess if they’ve got their mind made up they’re going to do it anyway.” (C8)

3.7.2 Intentions to cease OST prior to or on release

Overall, ten of 28 participants currently on OST reported a preference to cease treatment prior to or on release from prison. Additionally, five of nine participants who had ceased treatment during their current custodial episode had no plans to re-enter treatment prior to release. Participants who had ceased or intended to cease OST prior to or on release often cited what they perceived as negative aspects of OST in the community. The most common of these (mentioned in eleven interviews) was the need to attend a clinic on a daily basis. There were specific issues raised regarding logistics of transport to and from clinics, and difficulties associated with attending clinics during dosing hours while also maintaining employment. A small number of participants mentioned difficulties going on holidays or visiting relatives due to the constraints of daily dosing.

“I have two children, yes. That’s exactly right, because I can’t even work because the clinic doesn’t open until 8 o’clock in the morning, then it goes from 8 o’clock in the morning until 12 o’clock in the afternoon. Then it opens back up from the 2 o’clock in the afternoon till 3pm. Now how is anyone that’s going to have to get up and go to work...” (B1)

“I just don’t want to have them handcuffs on me, yeah...Just really you’ve got no choice, you’ve got to wake up and go to the clinic every morning, you know so...” (E3)

“You know, it’s restricting. I can’t go away, can’t do a lot of things.” (B3)

The second most common reason given for wishing to cease OST prior to or on release was a desire to avoid associating with other opioid users who would present at treatment clinics. Across the seven interviews which mentioned this issue, participants noted that associating with other OST clients had previously led to, or could lead to, drug relapse and criminal behaviour.

“It ties me in with crime, with the wrong people, there’s people - every methadone clinic I’ve been to, if you want to get drugs, the best place to go is a methadone clinic. Or the local [pub] - see at [clinic], everyone goes up and gets their methadone, they walk back down, they all sit in the one spot and that’s where they sell the pills, they sell the methadone, they sell everything there.” (B1)

“I’ve been on it eight years. I guess ... I don’t know, I find that I tend to sort of run into old friends, go and pick up at the clinic, and that’s how I will start using again and I just want to, yeah, be done with it.” (B3)

A theme identified in five interviews was that OST was replacing one addiction for another. They reported wanting to be completely drug-free on their release, seeing methadone and buprenorphine-naloxone as analogous to illicit opioids, as opposed to a medication. Participants raising this issue referred to their desire to ‘be straight’, ‘be normal’ and ‘be completely clean’, and their perception was that these goals were in conflict with OST.

“No, I wouldn’t go anywhere near it. I am the stage where if you’re going to give it up you might as well just give it all up, man. There’s no substitute for it.” (E6)

Among participants wanting to cease OST prior to or on release, seven mentioned a desire to avoid withdrawal from OST in the community, specifically, methadone withdrawal. For these participants, continued OST post-release did not appear to be a consideration at all; rather, the decision to be made was that of when best to withdraw from OST. Participants’ perceptions were that methadone withdrawal was a lengthy, physically demanding, process, and that the less time they were prescribed methadone, the less intensive these withdrawal symptoms would be. Participants reported that they thought the withdrawal process would be easier to endure in prison, as they could focus on taking care of themselves in prison, and also that there was less chance of relapse to illicit opioid use due to limited accessibility of drugs.

“Well, what I can say is I was probably on the bup probably as long as I experimented with the methadone. There is a whole lot of difference to withdrawing with the drug. Methadone, it’s just I would never, ever, ever want to come off that again. It’s just horrible, you know, the slurping, the ...Just everything that comes with it, the sweating, just your legs, how they just constantly twitch. You know, can’t sleep, the hot and cold flushes, the vomiting.” (A1)

A final motivation for ceasing methadone prior to release to the community was the stigma that can be attached to OST. Participants in this group reported not wanting their children, family members or employers to know that they were prescribed OST, and that there was stigma attached to long term use of opioid substitute medications and being an ‘injecting drug user’ or ‘criminal’.

“Yeah, I’ve got two kids as well and when I do get my kids back, I don’t want my kids knowing.” (B3)

“It’s just that everyone knows if you’re on methadone you’ve had a drug problem and that. And I think some people just get too stoned on it in the community.” (E5)

3.7.3 Availability and use of drugs in prison

Across groups, there was a consensus that drugs including cannabis, heroin, methamphetamine and buprenorphine-naloxone were available in prison. Buprenorphine-naloxone in prison may be diverted from the opioid treatment program (described in more detail below), or may be smuggled in from outside prison. Participants differed in their perceptions of the most readily available drug.

“These city jails are full of everything. The ones close to Sydney are full of everything; you can get everything – there’s ice and heroin and there’s everything. The further you go out to the country, people aren’t visiting as frequent, there’s a little bit less; it’s more probably inside bup and stuff like that.” (D5)

“Yeah. Um (pause) like I come in, I hunted drugs every day. I know a lot of girls in here even from the outside, it’s very easy, really easy.” (C9)

Pricing for drugs in prison appeared to vary in accordance with the prison location (metropolitan versus rural) and by substance type. Payment methods included money, but also other currencies such as tobacco (‘White Ox’) and buy-ups (goods that can be purchased on a weekly basis such as food, clothing, items).

Interviewer: Is it physical money?

C1: Or get money put into an account outside and shit.

Interviewer: Yeah, because how much food or buy up stuff ...

C1: Smokes, White Ox. A big trade in here, White Ox.

A2: Gear, bup. whatever you can get your hands on really.

Interviewer: And how does it work, do they exchange things or do you put money in...

A2: Yeah you exchange things, you buy it naturally. But it's not the sizes you get on the outside, it's like - it's heaps smaller than what you get on the outside. So it's not really a habit in here compared to what you get on the outside. In here, a lot of girls it's just a mental thing. They think they're sick but they're not.

Interviewer: And what was your habit or what did you need to hold you I guess I'm saying.

B11: If it was heroin, say a half weight. And of bup maybe --- almost an 8ml tablet a day or something like that; sometimes more, sometimes one and a half tablets.

Interviewer: And how did you pay for it?

B11: When I got out at the beginning of 2011 I um, like I was still working and stuff in the meantime and I accumulated enough money to buy a car and all that sort of stuff and since I've been in jail this time I've had to sell it all to be able to pay for all the crap, you know.

"Um, I don't - I haven't ever really paid for my drugs. I know a lot of girls in here - I think I've paid once, and for a 8ml of bup. it's a full pouch, 30gm one...Mm-hm. Or if you're - sometimes buy-ups, you know stuff like that. But I've only ever paid once for - for drugs. I've never had to pay....Yeah I've known a lot of these girls, I've done a lot of juvie [juvenile detention] with them, known them on the outside." (C9)

Specific costs of drugs as reported by participants included \$400 for 1g of heroin; 1 pouch of tobacco for 0.1g of methamphetamine; 1 pouch of tobacco for 8mg of buprenorphine; and ½ pouch of tobacco for 2 cones of cannabis.

Participants mentioned that drugs could be obtained from visitors.

C3: Yeah, then when I come down here, I come down here end of 2009, I think it was. Yeah, and that's when I started back on the bup.

Interviewer: And that was smoking it in prison or on the program?

C3: No, just getting it off people, like, with visits and stuff like that.

One participant expressed concern that people returning from visits were stood over on the assumption that they had been given drugs.

Injecting did appear to be a prominent way, along with smoking, to administer drugs in prison.

"I'd say so, yeah. I don't. Like on the outside I use needles but not inside; I just smoke it on the inside. I'm not playing Russian roulette with my life like that." (C11)

Reported frequency of injection varied. Participants reported injecting to self-medicate withdrawal symptoms after coming into custody; others noted injecting while waiting to commence OST. Participants sometimes reported their injecting drug use to health care workers in an effort to expedite their entry to OST. Fewer participants reported that they injected drugs to 'get high'.

Awareness of the potential for HIV and HCV transmission through sharing of needles and syringes was high. There was consensus that sharing needles and syringes was not an attractive option, but with few avenues for obtaining sterile injecting equipment, it was viewed as a necessity.

"Oh, I've never done it but you see them in the showers, sharing. One of them has got to have it, that's it, and the rest get it. It's terrible. It's pretty bad." (C4)

"In gaol, I think they've got to take this two month waiting list thing away. They have to. It's- I'm telling you the Hep C and AIDS rate is just going to skyrocket. You know I've seen like five plus girls use one fit at one sitting you know." (C8)

Access to needles and syringes in prison fell into three areas: those who brought concealed syringe into custody, those who purchased their syringe in custody and those who shared injecting equipment in custody. Precarious methods were described for the concealment of injecting equipment and substances when entering custody. Methods were also described for 'cleaning' syringes. Black market prices in prison for syringes were also discussed.

C1: I bring my own with me every time I come in. I've always walked around with my little parcel. Three brand new fits cut down and a heap of tablets ... because it could be a month or two before I settle in and get a routine up.

Interviewer: Did they not pick that up when you came in?

C1: No, you swallow it and keep it in your guts until you get through.

Interviewer: And then how do you dispose of your fits? Do you pass them on?

C1: No, I just pass them on, sell them. When I'm finished with them, I say, 'Here you are.' Because anyone will buy them. They use them until they're dead.

Interviewer: What do they go for?

C1: A hundred bucks.

Interviewer: So how many would you say share it?

C1: Thirteen.

Interviewer: The needle, was it someone else's?

C5: No, it was mine but it was used before but by somebody else. I mean, I bleached it and that. I used to bleach it all the time.

Interviewer: How do you get bleach in here?

C5: Fincol, they clean with it.

Participants raised the possibility of a needle and syringe program in prison, which in their view would be run by medical staff.

"And if they gave out needles that would stop people sharing. Like a needle exchange, only through the nurses, but they can't tell the screws. They've got the oldest needles, falling apart. They put plastic on it so they don't come off and five people using this. They don't even know if they've got HIV. How are they supposed to know? They could have HIV and not even know about it and the person who's used it, they're not going to go, 'I've got HIV.' So who knows? You could have people now with HIV. They're not going to know until they get a blood test, so they should do needle ... you know, where you go see the nurse and you go, 'Look, I've got a needle. Can I swap it?' That stops diseases." (B4).

3.7.4 Diversion of buprenorphine-naloxone

The issue of buprenorphine-naloxone diversion was mentioned in 18 interviews. Participants noted that patients who were prescribed buprenorphine-naloxone were targeted by others to divert their medication. The impression was given that buprenorphine-naloxone was a sought-after substance which was reportedly inexpensive and available throughout various prisons.

Information regarding diversion practices varied. Most participants described buprenorphine-naloxone diversion in terms of being 'stood over' that is, forced to give their dose to another individual. Standover tactics ranged from being repeatedly 'asked' to the point of annoyance for their medication, through to intimidation tactics of verbal threats, alienation, physical intimidation (such as the practice of 'going up with them to get dosed' (C9)), aggression and abuse.

Perpetrators of standover behaviour were generally reported as people not on OST who were self-medicating withdrawal symptoms (e.g. "...coming in off the streets and hanging out for drugs"(B10)). There were also reports of individuals who obtained diverted OST medicines to experience opioid intoxication, or to profit from selling the medicines. Victims of standover tactics were generally reported to be newcomers to the prison system, however there were relatively recent personal accounts from interviewees, many of whom had served longer custodial sentences and still reported being approached to divert their buprenorphine-naloxone (and methadone) medication.

"See, like if they wanted to get rid of the problem by making it so hard to get on it and ... if they just put everyone on the bup so easily there'd be no value. Like, when bup first come to jail you couldn't sell it because you'd get bashed. You were trying to sell something that the jail gives you for free, you know what I mean? And because there was no market then, so if everyone was on bup then you couldn't sell it because he'd have it and he'd have it and he'd have it. So there's no competition, you know what I mean?" (B4)

Both the tablet and film formulations of buprenorphine-naloxone were reportedly able to be diverted, with the film formulation reported to be slightly easier than the tablet formulation. From patient reports, less effort was needed to divert the film as it just 'sticks to your gums': patients reported if they ensured their gums were dry they were able to peel the film off. With the tablet formulation, diversion techniques included sticking a piece of bread in a small ball to the roof of the mouth, then using the tongue to conceal the tablet in the bread.

Routes of administration of diverted buprenorphine-naloxone included smoking and injecting. The film formulation was reportedly easier to inject, by adding warm water, as opposed to crushing and dissolving the tablet. There was consensus that those using buprenorphine-naloxone had broadened to include a younger cohort who were relatively opioid naïve and would begin by smoking buprenorphine-naloxone, as opposed to the older opioid dependent person who primarily injected drugs.

Interviewer: How long would one [buprenorphine-naloxone] tablet last?

C1: Ten shots, if you keep it to yourself, you know what I mean, you'll get 10 shots out of it.

B1: It's not really big in methadone, it's more big in bup, a lot of people get stood over for their bup here, and only four people of the 200 girls on here are allowed to be on bup. If you come in and if there's only four girls on bup, bad luck, you're going on methadone. See that's not fair either.

Interviewer: So bup's better, people think bup is better, because...

B1: Oh yeah, because they can smoke it, they can shoot it up, people really, really - it's very popular.

Interviewer: How do they smoke it?

B1: See I think they just crush it up and like get a piece of foil, and light the foil underneath and roll up like a - you know a pen, open up your pen and then break it, then put the foil there, and have - put the foil with the drug on it there, light it there and then just smoke it.

Interviewer: Oh smoke it through the pen.

B1: Yeah.

Interviewer: Have the bup on top of the foil and you light it underneath the foil and the fumes...

B1: Yeah, yeah. And it's supposed to be like - I know a lot of girls that - they love it.

3.7.5 Use of OST for chronic pain

Five participants (A4, C4, C7, C8, E7) made specific mention of using OST in prison to medicate chronic pain conditions from previous accidents (e.g. motor vehicle accidents). Methadone was perceived as one of the primary pain management options provided in prison.

"They wanted to put me on methadone for pain relief for my wrist. I didn't want it. No, I'm not getting back on methadone again." (E7)

"And when I got to [prison] they put me on it [methadone treatment] ... plus my back's pretty bad and I couldn't handle the pain anymore. It was the only way." (C4)

"I was just so sick you know, I wasn't meant to bear any weight on my leg. I had a boot on this leg for what, 10 months but yeah I've got a 4mm gap in the bone so I've got to go and have an operation on it. So I'm walking round with a broken leg all day, and it hurts you know. So they made me go back on the methadone for pain treatment." (C8)

Two other points raised by participants were the inadequacy of the previous medications that were given for chronic pain (prior to commencing methadone treatment), and the difficulty in accessing these medications in prison.

"It's [methadone treatment] a hell of a lot better than fighting for Nurofen....I mean it aches chronically, but yeah it's a lot better than what it was....I mean there's no other pain medication that I can really have here, they won't give me anything else" (C8).

A4: *It's because I almost broke my back going down some stairs. Ever since then it's like ... I didn't break it or no damage to it but it's been ... like, a shooting pain goes through my back.*

Interviewer: *Did they give you anything here when you weren't on the program, for the pain?*

A4: *Panadol, like that's going to do anything.*

C7: *Yeah, I come down from 60 to 20 [mg of methadone], I didn't really feel it but it's ... from then on is when I will feel it. Yeah, but hopefully I'll be back on the Tramadol. I need some kind of pain management.*

Interviewer: *So are you having to use on top of what you're getting methadone wise?*

C7: *Sometimes but I try not to. (for pain)*

Interviewer: *How regular is it [extra use]?*

C7: *Once, maybe twice, a week.*

Interviewer: *Yeah, and what are you getting? Is it mostly bup or methadone on top?*

C7: *Methadone or oxycontin, sometimes Xanax.*

3.7.6 Naltrexone for the treatment of opioid dependence

Participants were asked if they had heard of naltrexone for the treatment of opioid dependence. Over half (27/47) of participants had heard of naltrexone tablets and/or implants. Four participants reported previously having a naltrexone implant, or having undergone rapid detoxification under sedation (B3, D6, D8, E3).

D8: *I've had the Naltrexone implant.*

Interviewer: *Oh, right. Can you tell me a bit about that?*

D8: *Yeah, I had it in 2003. I found it really, really good actually.*

Interviewer: *How long did you have it for?*

D8: *The one that I had was for nine months, like it was the 3 x 3 month rods that I had. Yeah, and I stayed clean for about a year and a half, yeah, from the Naltrexone. You know, and then running into the old people again.*

Several participants who had heard of naltrexone were skeptical of the introduction of naltrexone in prisons as an alternative to OST, mainly because it was perceived that people being treated with naltrexone would use other drugs such as amphetamine (A4, B3, B8, B10, B11, D5, D9, E2, E6, E8).

"Yeah I've heard of them, but yeah I don't know about that because that's only to stop it from like heroin and that I think. You can still use ice and whatever, so it's not a deterrent for everything, it's only a deterrent for heroin." (E2)

"The implant, yeah. But they usually change drugs and go to amphetamines, the majority of what I've seen. It lasts for a while and then, 'Oh, I can't use heroin or bup.' So they'll go to amphetamines or another drug, cocaine or ... yeah." (E8)

4. DISCUSSION

4.1 Motivations for entering (or not entering) OST, and experiences of treatment entry

Treatment seeking was often precipitated by drug use and injecting in prison. OST was also sought to medicate opioid withdrawal symptoms. Reasons for not seeking OST included previous adverse side effects in OST, preference not to attend the clinic for daily dosing, and concerns about difficulty eventually withdrawing from OST, particularly from methadone.

Five participants were prescribed methadone for the management of chronic pain. These patients typically voiced a preference for other pain medication, such as that prescribed to them in the community prior to custody. Amid concerns about diversion of opioid analgesics or patients with opioid drug seeking and/or other aberrant behaviours, supervised methadone is generally considered the safest option for chronic pain management in the correctional setting, especially for patients with complex issues of both chronic pain and opioid dependence. Given the clinical challenges and complexities of assessing chronic pain in opioid dependent patients, and vice versa, JH&FMHN has in place a comprehensive policy to guide clinicians in the clinical management of patients on prescription opioid analgesics. Management of chronic pain in the correctional setting is likely to be an increasing issue as the prisoner population ages; further work examining the epidemiology of chronic pain in prisoner populations and assessment of how best to treat chronic pain patients in the correctional setting is needed.

There was considerable negative feedback from participants regarding the time taken to commence OST, from the initial request for assessment for suitability for the opioid treatment program, to the assessment itself, to treatment induction. Rapid increases in OST patient numbers in NSW correctional centres in recent years prompted a review of operational and safety aspects of the opioid treatment program in 2011, including the determination of the number of patients that could be safely managed both in custody and upon release to the community on OST. This has meant delays in accessing OST for those patients seeking to commence treatment in prison, and participants in this study clearly had strong negative views about this approach. Among some participants, the waiting list appeared to act as a barrier to initiating the process of commencing OST. Balancing the needs of opioid dependent patients against safety and security concerns is an ongoing challenge for clinical staff and managers.

4.2 Benefits and difficulties of OST in the correctional setting

With some exceptions, benefits of OST in prison were largely framed in terms of avoiding negative experiences or outcomes, rather than as direct positive benefits of treatment. For example, for many patients the primary benefit of OST was avoidance of opioid withdrawal symptoms. Avoidance of the illicit drug trade in prison, and avoidance of high-risk injecting drug use, were also identified as benefits. Several participants who were not currently in OST acknowledged these benefits, and noted their interest in commencing (and in some cases, re-commencing) OST while in custody. These findings highlight that although OST is perceived as preventing negative outcomes, it is not necessarily seen as producing positive outcomes for the individual, such as better health or quality of life. This is line with previous research that has reported the considerable ambivalence that many opioid dependent persons have towards OST (Harris & Rhodes, 2013).

Although only two participants in this study were currently prescribed buprenorphine-naloxone, there was widespread awareness that buprenorphine-naloxone was diverted from the opioid treatment program. Diversion of buprenorphine-naloxone appeared to most commonly occur in the context of patients being 'stood over' for their medicine, although there may also have been patients who voluntarily engaged in diversion. It was the perception of participants that people standing over others for buprenorphine-naloxone did so to medicate

their own opioid withdrawal symptoms shortly after entering custody, to achieve intoxication, or to sell for profit. The potential for diversion of buprenorphine products used for OST in correctional settings has been previously identified (Gordon et al., 2014; Kinlock et al., 2010; Magura et al., 2009), and the combination buprenorphine-naloxone film was introduced into NSW correctional centres specifically in response to concerns regarding diversion of mono-buprenorphine and buprenorphine-naloxone sub-lingual tablets. Organisational policies and procedures for reducing the incidence of diversion and for responding to identified cases of diversion are in place in correctional health centres in NSW.

4.3 Intentions to cease OST post-release

Despite the identified benefits of OST in prison, there was considerable ambivalence among patients regarding continuation of OST once released. Reasons for preferring to cease OST prior to or on release centred around perceptions that being prescribed OST would interfere with employment (due to the necessity of attending a clinic with opening hours that conflicted with work commitments), and increase their risk of drug use and criminal activity (through exposure to drug-using associates). These participants expressed a desire to be 'drug free', a goal they felt was in conflict with OST. The often-prolonged nature of OST was perceived negatively (and again, in conflict with being 'drug free'), and participants also noted the stigma associated with OST. Conversely, participants who planned to remain in OST post-release noted the stabilizing effects of treatment and its usefulness in preventing illicit drug use, particularly in the face of the multiple stressors often experienced by people leaving prison.

Some participants did not appear to consider continuation of OST on release to the community as an option at all. This group framed the issue of post-release treatment in terms of when best to withdraw from OST: prior to release through managed withdrawal, or 'jumping off' on release (i.e. abruptly ceasing treatment on release; that is, not engaging with community treatment providers). For these participants, withdrawing from OST prior to release was preferable to abrupt treatment cessation in the community.

Balancing the preference of many patients to cease OST prior to release against patient safety post-release is a substantial challenge for correctional health care workers. The weeks immediately after release from prison are associated with an elevated risk of drug-related death (compared to other time at liberty) (Merrall et al., 2010), and exposure to OST during this period is highly protective against mortality (Degenhardt et al., 2014). As such, correctional health care workers in NSW are trained to advise patients to remain in OST through their transition to the community, and are reluctant to assent to patient requests to cease OST prior to release. This tension between patient preference and evidence-informed clinical practice appears to be perceived by patients as a lack of consultation and/or poor treatment planning. Although this study has provided patient perspectives on this clinical interaction, we do not know how clinicians relay information about post-release risks to patients; a qualitative study of clinician perspectives of OST in prison may provide this information. Further work is also required to determine the best models of care for fostering engagement in OST post-release.

Given that some participants with histories of opioid use and dependence were reluctant to remain in OST following release, and other were uninterested in OST, there is a need for a range of interventions to address post-release mortality risk. Take-home naloxone programs have demonstrated that people who use opioids, as well as their friends and family members, can safely administer naloxone to reverse opioid overdose (Mueller, Walley, Calcaterra, Glanz, & Binswanger, 2015). Naloxone is routinely supplied to people with a history of opioid use released from Scottish prisons, with emerging evidence suggesting an impact on post-release overdose mortality (ISD, 2014). The supply of take-home naloxone to people released from custody should be explored in NSW and other correctional jurisdictions.

4.4 Illicit drug use in prison

Cannabis, heroin, methamphetamine and buprenorphine-naloxone were the drugs most frequently mentioned as being available in the prison system. Reported prices varied according to substance and geographical location of the correctional facility, but prices generally were more expensive than those seen in the Sydney illicit drug market (Stafford & Burns, 2014). Participants described drugs as being introduced to the prison system via visitors and new receptions, and through diversion of buprenorphine-naloxone from the opioid treatment program.

Participants reported injecting drug use and smoking as routes of drug administration. Awareness of the potential for HCV or HIV transmission through the sharing of injecting equipment was high; nonetheless, participants reported that sharing of needles and syringes was common. Access to needles and syringes in custody varied, with reports of needles and syringes being brought inside prison with the participant at the time they entered custody, purchased from other inmates, or made from materials within the prison.

Participants perceived a needle and syringe program as feasible for the prevention of re-use of injecting equipment. As of 2014, needle and syringe programs operated in prisons in eight countries (HRI, 2014). Needle and syringe programs have operated in community settings in Australia since the mid-1980s (Madden & Wodak, 2014); however, no such programs are offered in any Australian correctional setting. A proposed needle and syringe program in the Alexander Maconochie Centre, the Australian Capital Territory's only correctional centre, has not eventuated due to opposition from correctional officers (Bresnan, 2015).

4.5 Conclusions

This study has generated unique data on patient perspectives of OST in correctional settings. We have described patient perspectives on entry to, experiences of, and retention in, OST in prison and post-release. Our findings have highlighted the challenges facing opioid treatment providers in prison in addressing patient ambivalence towards OST and preferences to cease OST prior to release, and can inform the development of policies and clinical practices that are mindful of patient perspectives and concerns. These results are suggestive of the need for further work examining how best to attract and retain opioid dependent prisoners in treatment, including provider perspectives; evaluation of programs designed to increase post-release retention in OST (and other care); the implementation of alternative overdose prevention strategies such as take-home naloxone; and quantitative analyses of retention in OST in prison and post-release.

5. REFERENCES

- ABS. (2013). Prisoners in Australia, 2013. Canberra: Australian Bureau of Statistics.
- AIHW. (2013). The health of Australia's prisoners 2012. Canberra: Australian Institute of Health and Welfare.
- AIHW. (2014). National opioid pharmacotherapy statistics 2013. Canberra: Australian Institute of Health and Welfare.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Bresnan, A. (2015). Needle and syringe program opportunity lost for the ACT. *Canberra Times*. 15 April 2015. from <http://www.webcitation.org/6XwiXctyG>
- Degenhardt, L., Bucello, C., Mathers, B. M., Briegleb, C., Ali, H., Hickman, M., & McLaren, J. (2011). Mortality among regular or dependent users of heroin and other opioids: A systematic review and meta-analysis of cohort studies. *Addiction*, 106, 32-51.
- Degenhardt, L., Larney, S., Kimber, J., Gisev, N., Farrell, M., Dobbins, T., . . . Burns, L. (2014). The impact of opioid substitution therapy on mortality post-release from prison. *Addiction*, 109, 1306-1317.
- Dolan, K., Shearer, J., MacDonald, M., Mattick, R. P., Hall, W., & Wodak, A. (2003). A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence*, 72(1), 59-65.
- Gordon, M. S., Kinlock, T. W., Schwartz, R. P., Fitzgerald, T. T., O'Grady, K., & Vocci, F. J. (2014). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. *Drug and Alcohol Dependence*, 142, 33-40.
- Harris, M., & Rhodes, T. (2013). Methadone diversion as a protective strategy: The harm reduction potential of "generous constraints". *International Journal of Drug Policy*, 24, e43-e50.
- HRI. (2014). The Global State of Harm Reduction. London: Harm Reduction International.
- Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kumar, S., & McNamara, M. (2010). 2009 Inmate Health Survey: Key Findings Report. Sydney: Justice Health.
- ISD. (2014). National naloxone programme Scotland: Naloxone kits issued in 2013/14 and trends in opioid-related deaths. <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2014-10-28/2014-10-28-Naloxone-Report.pdf>: Information Services Division Scotland/NHS National Services Scotland.
- Kinlock, T. W., Gordon, M. S., Schwartz, R. P., & Fitzgerald, T. T. (2010). Developing and implementing a new prison-based buprenorphine treatment program. *Journal of Offender Rehabilitation*, 49, 91-109.
- Koester, S., Anderson, K., & Hoffer, L. (1999). Active heroin injectors' perceptions and use of methadone maintenance treatment: Cynical performance or self-prescribed risk reduction. *Substance Use and Misuse*, 34, 2135-2153.
- Larney, S. (2010). Does opioid substitution treatment in prison reduce injecting-related HIV risk behaviours? A systematic review. *Addiction*, 105, 216-223.
- Larney, S., Gisev, N., Farrell, M., Dobbins, T., Burns, L., Gibson, A., . . . Degenhardt, L. (2014). Opioid substitution therapy as a strategy to reduce deaths in prison: Retrospective cohort study. *BMJ Open*, 4, e004666. doi: <http://dx.doi.org/10.1136/bmjopen-2013-004666>
- Lind, B., Chen, S. L., Weatherburn, D., & Mattick, R. P. (2005). The effectiveness of methadone maintenance in controlling crime: An Australian aggregate-level analysis. *British Journal of Criminology*, 45, 201-211.
- MacArthur, G. J., van Velzen, E., Palmateer, N., Kimber, J., Pharris, A., Hope, V., . . . Hutchinson, S. J. (2014). Interventions to prevent HIV and hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness *International Journal of Drug Policy*, 25, 34-52.
- Madden, A., & Wodak, A. (2014). Australia's response to HIV among people who inject drugs. *AIDS Education and Prevention*, 26, 234-244.
- Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shronshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A

- randomized clinical trial. *Drug and Alcohol Dependence*, 99(1-3), 222-230. doi: 10.1016/j.drugalcdep.2008.08.006
- Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2009). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews, Issue 3*, Art. No. CD002209.
- Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews, 2*, Art. No. CD002207.
- Merrall, E. L. C., Kariminia, A., Binswanger, I. A., Hobbs, M., Farrell, M., Marsden, J., . . . Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction*, 105, 1545-1554.
- Mueller, S. R., Walley, A. Y., Calcaterra, S. L., Glanz, J., & Binswanger, I. A. (2015). A review of opioid overdose prevention and naloxone prescribing: Implications for translating community programming into clinical practice. *Substance Abuse*, 36, 240-253.
- Rodas, A., Bode, A., & Dolan, K. (2012). Supply, demand and harm reduction strategies in Australian prisons: An update. Canberra: Australian National Council on Drugs.
- Stafford, J., & Burns, L. (2014). Australian Drug Trends 2013. Findings from the Illicit Drug Reporting System (IDRS) *Australian Drug Trends Series no. 109*. Sydney: National Drug and Alcohol Research Centre, UNSW Australia.
- WHO. (2009). Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva: World Health Organization.

APPENDIX A: RECRUITMENT SITES

Site	N participants
Long Bay Correctional Centre	21
Silverwater Women's Correctional Centre	13
Metropolitan Remand and Reception Centre	4
John Morony Correctional Centre	4
Dillwynia Correctional Centre	2
Silverwater Men's Correctional Centre	2
Outer Metropolitan Multi-Purpose Correctional Centre	2

APPENDIX B: INTERVIEW GUIDES

Interview guide A: New patients (in treatment ≤28 days)

Interview date: ___/___/___ Interviewer name: _____

Correctional centre: _____

*****START THE TAPE RECORDER NOW*****

Introduction: *With this study, we want to understand what it's like being on methadone or bupe in gaol, and why some people choose not to go on methadone in gaol. We're talking to people who have been in treatment for a while, people who are just starting treatment and people who aren't in treatment at all. First, I'm going to ask you some basic information about yourself, and then I'd like to have a conversation about your experience with treatment. I'm tape recording all of it so that I can go back later and listen again to what you've said. Let me know if you want me to stop the tape recorder at any stage. Before we get started, do you have any questions about the study?*

Participant demographic information

1. Date of birth: ___ / ___ / ___

2. Sex: Male
 Female
 Transgender

3. Do you identify as Aboriginal or Torres Strait Islander?
 No
 Yes
 Refusal

4. Are you:
 On remand?
 Sentenced?
 Don't know
 Refusal

5. Is this your first time in adult gaol?
 No
 Yes
 Refusal

6. Are you on*:
 Methadone
 Subutex
 Suboxone
 Buprenorphine (not sure of formulation)

* If participant is unsure, enquire about whether it is a liquid (methadone) or crushed tablet (buprenorphine).

***** Please be certain that the tape recorder is on *****

1. Can you tell me about your reasons for starting methadone/bupe here in gaol?

[Prompts: had you been using in gaol? Had you been injecting? What were you injecting?]

2. Have you ever been on methadone/bupe in the community? *If yes: Can you tell me about your reasons for starting methadone/bupe outside?*

[Explore if there are differences between reasons for starting OST outside and reasons for starting OST inside]

3. What do you think you will get out of being on methadone/bupe in gaol?

[Prompts: Do you think it will help you in any particular way? Do you think certain things will change for you while you are on methadone/bupe? Do you think you might still inject heroin or any other drugs occasionally?]

4. Have you heard about people being stood over for their methadone/bupe?

[Prompts: Do you think anyone goes on methadone/bupe just so that they can divert it?]

5. Naltrexone is a tablet or implant that blocks the effects of opioids. Have you heard about naltrexone as a treatment option for heroin dependence? Do you think naltrexone would be a useful treatment option in gaol? [Why/why not?]

[Prompts: Would you ever go on naltrexone in gaol? Why/whynot?]

6. Have you thought about how long you want to stay on methadone/bupe?

[Prompts: Will you stay on OST until after you are released? *Explore reasons for staying in OST and/or reasons for wanting to come off OST, particularly in relation to leaving OST just before release*]

7. We've talked a bit about what it's like being on methadone/bupe in gaol; is there anything else that you wanted to mention before we finish up?

Interview guide B: Current patients, on OST prior to reception into custody

Interview date: ___ / ___ / ___ Interviewer name: _____

Correctional centre: _____

*******START THE TAPE RECORDER NOW*******

Introduction: *With this study, we want to understand what it's like being on methadone or bupe in gaol, and why some people choose not to go on methadone in gaol. We're talking to people who have been in treatment for a while, people who are just starting treatment and people who aren't in treatment at all. First, I'm going to ask you some basic information about yourself, and then I'd like to have a conversation about your experience with treatment. I'm tape recording all of it so that I can go back later and listen again to what you've said. Let me know if you want me to stop the tape recorder at any stage. Before we get started, do you have any questions about the study?*

Participant demographic information

1. Date of birth: ___ / ___ / ___

2. Sex: Male
 Female
 Transgender

3. Do you identify as Aboriginal or Torres Strait Islander?
 No
 Yes
 Refusal

4. Are you:
 On remand?
 Sentenced?
 Don't know
 Refusal

5. Is this your first time in adult gaol?
 No
 Yes
 Refusal

6. Are you on*:
 Methadone
 Subutex
 Suboxone
 Buprenorphine (not sure of formulation)

* If participant is unsure, enquire about whether it is a liquid (methadone) or crushed tablet (buprenorphine).

***** Please be certain that the tape recorder is on *****

1. Is coming into gaol already on methadone/bupe different from starting methadone/bupe in gaol?

[Prompts: why/why not/how? Would you start methadone/bupe in gaol for different reasons than you would outside? *Explore if there are differences between reasons for starting OST outside and reasons for starting OST inside*]

2. If you hadn't already been on methadone/bupe when you came into gaol, would you have gone on it?

[Prompts: why/why not?]

3. What do you get out of being on methadone/bupe in gaol?

[Prompts: Do you think it helps you in any particular way?]

4. Naltrexone is a tablet or implant that blocks the effects of opioids. Have you heard about naltrexone as a treatment option for heroin dependence? Do you think naltrexone would be a useful treatment option in gaol? [Why/why not?]

[Prompts: Would you ever go on naltrexone in gaol? Why/whynot?]

5. Have you heard about people being stood over for their methadone/bupe?

[Prompts: Do you think anyone goes on methadone/bupe just so that they can divert it?]

6. Have you used anything in gaol while you've been on methadone/bupe?

[Prompts: What have you used? Have you been injecting? Did you have any particular reason for using?]

7. Have you thought about how long you want to stay on methadone/bupe?

[Prompts: Will you stay on OST until after you are released? *Explore reasons for staying in OST and/or reasons for wanting to come off OST, particularly in relation to leaving OST just before release*]

8. We've talked a bit about what it's like on methadone/bupe in gaol; is there anything else that you wanted to mention before we finish up?

Interview guide C: Current patients, commenced treatment in prison

Interview date: ___ / ___ / ___ Interviewer name: _____

Correctional centre: _____

*****START THE TAPE RECORDER NOW*****

Introduction: *With this study, we want to understand what it's like being on methadone or bupe in gaol, and why some people choose not to go on methadone in gaol. We're talking to people who have been in treatment for a while, people who are just starting treatment and people who aren't in treatment at all. First, I'm going to ask you some basic information about yourself, and then I'd like to have a conversation about your experience with treatment. I'm tape recording all of it so that I can go back later and listen again to what you've said. Let me know if you want me to stop the tape recorder at any stage. Before we get started, do you have any questions about the study?*

Participant demographic information

1. Date of birth: ___ / ___ / ___

2. Sex: Male
 Female
 Transgender

3. Do you identify as Aboriginal or Torres Strait Islander?
 No
 Yes
 Refusal

4. Are you:
 On remand?
 Sentenced?
 Don't know
 Refusal

5. Is this your first time in adult gaol?
 No
 Yes
 Refusal

6. Are you on*:
 Methadone
 Subutex
 Suboxone
 Buprenorphine (not sure of formulation)

* If participant is unsure, enquire about whether it is a liquid (methadone) or crushed tablet (buprenorphine).

***** Please be certain that the tape recorder is on *****

1. Can you tell me about your reasons for starting on methadone/bupe while in gaol?

[Prompt: Had you tried to get on treatment before you came in, but couldn't?]

2. Have you ever been on methadone or buprenorphine outside? *If yes:* Those times when you have started methadone/bupe in the community, do you think your reasons for starting treatment were different than your reasons for starting treatment while in gaol?

3. What do you get out of being on methadone/bupe in gaol?

[Prompts: Do you think it helps you in any particular way?]

4. Naltrexone is a tablet or implant that blocks the effects of opioids. Have you heard about naltrexone as a treatment option for heroin dependence? Do you think naltrexone would be a useful treatment option in gaol? [Why/why not?]

[Prompts: Would you ever go on naltrexone in gaol? Why/whynot?]

5. Have you heard about people being stood over for their methadone/bupe?

[Prompts: Do you think anyone goes on methadone/bupe just so that they can divert it?]

6. Have you used anything in gaol while you've been on methadone/bupe?

[Prompts: What have you used? Have you been injecting? Did you have any particular reason for using?]

7. Have you thought about how long you want to stay on methadone/bupe?

[Prompts: Will you stay on OST until after you are released? *Explore reasons for staying in OST and/or reasons for wanting to come off OST, particularly in relation to leaving OST just before release*]

8. We've talked a bit about what it's like on methadone/bupe in gaol; is there anything else that you wanted to mention before we finish up?

Interview guide D: Former patients

Interview date: ___ / ___ / ___ Interviewer name: _____

Correctional centre: _____

*******START THE TAPE RECORDER NOW*******

Introduction: *With this study, we want to understand what it's like being on methadone or bupe in gaol, and why some people choose not to go on methadone in gaol. We're talking to people who have been in treatment for a while, people who are just starting treatment and people who aren't in treatment at all. First, I'm going to ask you some basic information about yourself, and then I'd like to have a conversation about your experience with treatment. I'm tape recording all of it so that I can go back later and listen again to what you've said. Let me know if you want me to stop the tape recorder at any stage. Before we get started, do you have any questions about the study?*

Participant demographic information

1. Date of birth: ___ / ___ / ___

2. Sex: Male
 Female
 Transgender

3. Do you identify as Aboriginal or Torres Strait Islander?
 No
 Yes
 Refusal

4. Are you:
 On remand?
 Sentenced?
 Don't know
 Refusal

5. Is this your first time in adult gaol?
 No
 Yes
 Refusal

***** Please be certain that the tape recorder is on *****

1. Can you tell me about your reasons for coming off methadone/bupe in gaol?

[Prompts: Did you discuss ending treatment with anyone? Did anyone else influence your decision to end treatment?]

2. What are some of the good things about being on methadone/bupe in gaol?

3. What are some of the less appealing things about being on methadone/bupe in gaol?

4. Naltrexone is a tablet or implant that blocks the effects of opioids. Have you heard about naltrexone as a treatment option for heroin dependence? Do you think naltrexone would be a useful treatment option in gaol? [Why/why not?]

[Prompts: Would you ever go on naltrexone in gaol? Why/whynot?]

5. Have you heard about people being stood over for their methadone/bupe?

[Prompts: Do you think anyone goes on methadone/bupe just so that they can divert it?]

6. How has your drug use changed from when you were on treatment to now?

[Prompts: Did being in treatment help you to not use/inject? Do you inject more or less when you are not in treatment?]

7. Have you thought about going back on methadone/bupe while you're still in gaol?

[Prompts: How would things be different if you were back on methadone/bupe? Would you rather try a different treatment, like naltrexone?]

8. We've talked a bit about what it's like being on methadone/bupe in gaol; is there anything else that you wanted to mention before we finish up?

Interview guide E: Heroin users, not in treatment

Interview date: ___/___/___ Interviewer name: _____

Correctional centre: _____

*******START THE TAPE RECORDER NOW*******

Introduction: *With this study, we want to understand what it's like being on methadone or bupe in gaol, and why some people choose not to go on methadone in gaol. We're talking to people who have been in treatment for a while, people who are just starting treatment and people who aren't in treatment at all. First, I'm going to ask you some basic information about yourself, and then I'd like to have a conversation about your experience with treatment. I'm tape recording all of it so that I can go back later and listen again to what you've said. Let me know if you want me to stop the tape recorder at any stage. Before we get started, do you have any questions about the study?*

Participant demographic information

1. Date of birth: ___ / ___ / ___

2. Sex: Male
 Female
 Transgender

3. Do you identify as Aboriginal or Torres Strait Islander?
 No
 Yes
 Refusal

4. Are you:
 On remand?
 Sentenced?
 Don't know
 Refusal

5. Is this your first time in adult gaol?
 No
 Yes
 Refusal

***** Please be certain that the tape recorder is on *****

1. Have you ever been on methadone or buprenorphine, either in prison or in the community?

[If yes: Can you tell me about your reasons for going on methadone/bupe?]

[If no: Are there any particular reasons why you've not gone on methadone/bupe?]

2. When you came into gaol (this time), was there any particular reason you didn't go on the waiting list to go on methadone or buprenorphine?

3. What do you think about methadone and buprenorphine as treatment options in gaol?

[Prompts: Would you ever consider going on methadone/bupe in gaol? What would have to change or be different for you to go on methadone/bupe in gaol?]

4. Naltrexone is a tablet or implant that blocks the effects of opioids. Have you heard about naltrexone as a treatment option for heroin dependence? Do you think naltrexone would be a useful treatment option in gaol? [Why/why not?]

[Prompts: Would you ever go on naltrexone in gaol? Why/whynot?]

5. We've talked a bit about methadone/bupe in gaol; is there anything else that you wanted to mention before we finish up?

APPENDIX C: PARTICIPANT CODES AND DEMOGRAPHICS

Group A: New inductions to OST

Code	Sex	Age	Indigenous	Prescribed
A1	Female	30	Yes	Methadone
A2	Female	22	Yes	Methadone
A3	Female	29	Yes	Methadone
A4	Female	32	No	Methadone
A5	Male	56	No	Methadone
A6	Male	43	Yes	Methadone
A7	Male	40	No	Methadone

Group B: Continuing OST from the community

Code	Sex	Age	Indigenous	Prescribed
B1	Female	26	No	Methadone
B2	Female	35	No	Methadone
B3	Female	28	No	Methadone
B4	Male	30	No	Methadone
B5	Male	35	No	Methadone
B6	Male	50	No	Methadone
B7	Male	44	Yes	Methadone
B8	Male	26	No	Methadone
B9	Female	27	Yes	Methadone
B10	Female	23	Yes	Methadone
B11	Male	36	No	Suboxone

Group C: Commenced OST in custody

Code	Sex	Age	Indigenous	Prescribed
C1	Male	37	Yes	Methadone
C2	Male	32	Yes	Methadone
C3	Male	41	No	Methadone
C4	Male	56	No	Methadone
C5	Male	53	No	Methadone
C6	Male	28	Yes	Methadone
C7	Male	31	No	Methadone
C8	Female	28	Yes	Methadone
C9	Female	24	No	Methadone

Group D: Voluntarily ceased OST in custody

Code	Sex	Age	Indigenous
D1	Male	42	No
D2	Male	21	Yes
D3	Male	26	Yes
D4	Male	44	Yes
D5	Male	38	No
D6	Male	34	No
D8	Female	28	No
D9	Male	32	Yes
D10	Male	51	No

Group E: No OST in current custodial episode

Code	Sex	Age	Indigenous
E1	Male	27	Yes
E2	Male	35	No
E3	Male	41	No
E4	Male	45	Yes
E5	Male	25	Yes
E6	Male	45	No
E7	Male	37	No
E8	Male	43	No
E9	Female	30	No
E10	Female	34	No