Addiction

# Letters to the Editor

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## UNIVERSAL HEPATITIS B VIRUS VACCINATION IN FRENCH PRISONS: BREAKING DOWN THE LAST BARRIERS

The February issue of *Addiction* reports results from the systematic review by Larney [1] which, due to the scarcity of studies, provide limited support for opioid substitution treatment as a method for reducing injecting-related human immunodeficiency virus (HIV) and therefore hepatitis B virus (HBV) risk behaviours in prison. Justifiably, the editorial by Farrel, Strang & Stover on the same issue [2] supports HBV vaccination for inmates as a targeted universal harm reduction (HR) intervention to overcome existing barriers to the implementation of HBV risk reduction measures in prison.

Many HBV cases still occur during prison stay due to persisting unsafe injecting and sexual practices [3], but these could be prevented by an adequate HBV vaccination strategy [4]. The MANIF 2000 cohort data show that among 467 HIV-infected injecting drug users (IDUs), only 35 were HBV-negative and the two major risk factors associated independently with HBV-seropositivity were older age and a history of incarceration. Since 1993 French public health authorities have recommended systematic hepatitis B vaccination in groups at high risk of transmission, including injecting drug users (IDU) and HIV-infected patients. However, a retrospective analysis performed on sera of the 35 HBV-negative patients showed that three experienced HBV seroconversion during follow-up, with an incidence rate of 3.4 per 100 person-years; two of these three patients reported sexual risk behaviours only.

One previous survey also revealed that French IDUs were less likely to be vaccinated against hepatitis B than the general population [5], while other research has shown that hepatitis B vaccination can be feasible and effective among drug users [6] and prisoners [7]. The editorial also emphasizes that there is a broad but not 'universal' consensus on hepatitis B vaccination.

In effect, since 1990 the French HBV vaccine campaign has faced public and professional doubts about the potential link between HBV vaccination and onset of central nervous system (CNS) inflammatory demyelination [8]. To what extent this association may influence HBV vaccination in prison settings is difficult to say. At any rate, the proportion of inmates vaccinated against HBV upon prison entry increased from 13.7% in 1997 to 31.3% in 2003 [9], probably thanks to the HBV vaccination campaign in the general population. However, updated information about HBV vaccination in French prisons is needed. Although the French National Authority for Health (HAS) guidelines in 2003 [10] recommended HBV vaccination strongly in prisoners, the 2004 HAS guidelines [11] mitigated the content of the former, suggesting that decisions about HBV vaccination should take into account individual risks and community benefits. It is possible that the difficulty in realizing a full immunization programme for prisoners may be an additional barrier. Nevertheless, equivalent accelerated strategies based on injection at days 0, 10 and 21 are effective and need to be promoted [7,12].

Full integration of HBV vaccination in a package of HR measures is not only a major public health opportunity in drug users and HIV-infected individuals but a priority in prison settings, where the efficacy of other HR measures may also need further research.

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## IMPROVING ACCESS TO OPIATE ADDICTION TREATMENT FOR PRISONERS

Larney highlights the limited evidence base regarding the impact of opiate substitution therapy (OST) in prisons on injection drug use (IDU), IDU-related human immunodeficiency virus (HIV) risk behaviors and HIV outcomes, calling for new research on this important topic [1]. Given that nearly all heroin injectors nation-wide are incarcerated at some point during their lives, the correctional setting provides an important opportunity to treat a hard-to-reach population with proven, evidence-based pharmacological therapy [2].

We recently conducted a nation-wide mixed-method survey of state and federal prison medical directors about OST prescribing attitudes and practices; our findings help to explain several of the complex factors underlying this limited evidence base [3]. We found that in spite of the proven health, social and economic benefits of providing OST [4–8], only 55% of prisons in the United States provide methadone to inmates in *any* circumstance, and most provide only to pregnant women [3]. Only 14% of prisons provide buprenorphine to prisoners while incarcerated [3]. While this represents a marked improvement in access to OST in correctional settings since 2002 [9], only a minute fraction of the estimated 200 000 incarcerated individuals with opiate dependence have access to OST [3]. Moreover, our survey found that the overwhelming majority of prisons also do not offer referrals to OST providers and programs to inmates upon release because of preferences for drug-free detoxification over pharmacological treatment of opiate dependence and limited partnerships with community providers, among other reasons [3].

Many prisons adopt abstinence-only policies because of philosophical opposition to pharmaceutical treatment of opiate dependence and preference for abstinence-only programs for incarcerated individuals [3]. These policies reflect a common misconception that opiate dependence is cured when drug use and withdrawal symptoms cease and ignores empirical evidence demonstrating high rates of relapse and alarmingly high rates of opiate overdose among people recently released from prison [10,11]. Other factors also play a role in limiting OST in correctional settings; even medical directors receptive to providing OST often face administrative and budget constraints that limit implementation of OST programs [3]. Moreover, other research finds that security concerns and philosophical opposition to OST by correctional staff can impede expansion of OST in correctional settings [12].

We have a 20-year history of collaborating with the Rhode Island Department of Corrections and have managed to overcome many of these barriers. However, collaborating has required significant time and commitment from both parties. This collaboration has resulted in numerous federally funded research and service grants which have greatly benefited hundreds of opiate-dependent individuals leaving the correctional setting.

Building the evidence base about the health, social and economic benefits of providing OST in correctional settings will probably require more than simply financing new research studies. Advancing OST research and programs in correctional settings will require educating medical directors and administrators about the social, medical and economic benefits of OST; overcoming administrative and political opposition to pharmacological treatment of opiate dependence; understanding and successfully addressing the security concerns of prison officials and staff; and overcoming severe budget constraints.

### Declarations of interest

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