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Challenges to implementing opioid substitution therapy in Ukrainian prisons: Personnel attitudes toward addiction, treatment, and people with HIV/AIDS

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ABSTRACT

Background: Ukraine is experiencing one of the most volatile HIV epidemics globally, fueled primarily by people who inject drugs (PWIDs), and a parallel incarceration epidemic. Opioid substitution therapy (OST) is internationally recognized as one of the most effective forms of treatment for opioid dependence and is among the most effective HIV prevention strategies available, yet efforts to adopt it in Ukraine's Criminal Justice System (CJS) have been thwarted.
Methods: To understand the reluctance of the Ukrainian CJS to adopt OST despite the overwhelming evidence pointing to its health benefits and improved criminal justice outcomes, we conducted the first survey of Ukrainian prison administrative, medical and custodial staff ($N = 243$) attitudes towards addiction in general, OST, and people living with HIV/AIDS (PLWHA) in representative regions of Ukraine.
Results: Results revealed that Ukrainian CJS workers' attitudes toward OST, PLWHA, and drug addiction were universally negative, but differed substantially along geographic and occupational lines. Whereas geographic and cultural proximity to the European Union drove positive attitudes in the west, in the southern region we observed an identifiability effect, as workers who worked directly with prisoners held the most positive attitudes. We also found that knowledge mediated the effect of drug intolerance on OST attitudes.
Conclusion: In Ukraine, adoption of OST is more influenced by myths, biases and ideological prejudices than by existing scientific evidence. By elucidating existing attitudes among CJS personnel, this study will help to direct subsequent interventions to address the barriers to implementing evidence-based HIV prevention treatments.

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1. Introduction

HIV/AIDS incidence has decreased globally, but despite these encouraging trends, the epidemics in countries of the Former Soviet Union (FSU) in Eastern Europe and Central Asia continue to expand (Joint United Nations Programme on HIV/AIDS, 2014; UNAIDS, 2013). Ukraine is experiencing one of the most volatile HIV epidemics in the world, with an estimated 230,000 people living with HIV/AIDS (PLWHA), fueled primarily by people who inject drugs (PWIDs), although there is emerging evidence for a transition to the general population (Azbel et al., 2013; Bojko et al., 2013; Joint United Nations Programme on HIV/AIDS (UNAIDS), 2014).

Opioid substitution therapy (OST) is one of the most effective and cost-effective strategies for curbing HIV transmission (Alistar et al., 2011) in community settings as well as in prisons (Stallwitz and Stover, 2007; Stover et al., 2006), resulting in reduced rates of drug use, infectious disease transmission, criminal activity, and recidivism (Altice et al., 2010). Community-based OST (first with buprenorphine and then with methadone) has been available in Ukraine for more than a decade. Expansion of OST, however, has been limited among the estimated 310,000 PWIDs and appears to differ regionally (Zaller et al., 2014). Efforts to

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improve entry and retention in OST have been thwarted by negative attitudes toward PWIDs, lack of knowledge about HIV and addiction treatment, and absence of integrated care (Degenhardt et al., 2013; Wolfe et al., 2010; Zaller et al., 2014). Furthermore, albeit 2011 legislation allowing it, and despite evidence of its benefit to reduce the negative consequences of drug injection within prison (Larney et al., 2012), and to improve transitional care post-release (Kinlock et al., 2009; Springer et al., 2012), OST has not yet been introduced into the Ukrainian criminal justice system (CJS). With almost 138,000 prisoners (305 prisoners per 100,000 population) in Ukraine (Walmsley, 2014), of which 48.7% are estimated to be PWIDs, HIV/AIDS and other infectious diseases are concentrated within Ukraine's prisons (Azbel et al., 2013, 2014). As prisoners cycle in and out of criminal justice settings (CJS), access to and retention in treatment is disrupted (Maru et al., 2007). Without reentry initiatives to provide continuity of care upon release, prisoners are especially vulnerable to substantial risks including relapse to drug use, overdose, and death (Binswanger et al., 2013, 2007). In the absence of adequate alternatives to incarceration for PWIDs, the CJS serves as a sentinel place for screening and the initiation of disease prevention and treatment measures for a population that is otherwise missed by public health systems (DeBell and Carter, 2005; Flanigan et al., 2010; Izenberg and Altice, 2010).

The few published studies on the health status of prisoners in countries of the FSU, and Ukraine in particular, report on the burden of infectious diseases (Azbel et al., 2013, 2014) and numerous patient-centered barriers to adequate care and community reentry (Morozova et al., 2013). A review of substance use disorders and HIV in prisons available from government sources in Central Asia strongly suggests that the existing estimates of drug abuse and infectious diseases remain markedly under-reported (Vagenas et al., 2013). Research initiatives adhering to international standards in Ukraine are hampered by logistical, financial, and political constraints, as well as by skepticism toward change and concerns about transparency on the part of the CJS officials (UNODC, 2012).

It is well-documented that healthcare providers' (Lev-Ran et al., 2013; Talal et al., 2013; Tracy et al., 2009) and prison personnel's (Caplehorn et al., 1998; Springer and Bruce, 2008; Stover et al., 2006) attitudes contribute to the quality of the care that patients ultimately receive. Globally and historically, treatment for opioid dependence has been more influenced by moral biases and prejudices than by scientific evidence (Torrens et al., 2013). In many settings, including high-income countries where OST is accepted in community settings, its extension to CJS remains controversial (Larney and Dolan, 2009). The opposition to OST is unsubstantiated, as research shows that commonly expressed concerns regarding the introduction of OST by prison administrators, such as drug diversion, security, and violent behaviors, disappear after the programs are implemented (Jurgens et al., 2011; Magura et al., 2009). Nevertheless, despite the explicit recommendation by WHO and UNAIDS (2006) to CJS authorities to urgently introduce and expand OST programs, negative attitudes toward and stigma against OST have persistently impeded its adoption in prison systems around the world.

This is particularly true in Ukraine's neighboring Russia and in some FSU countries where OST is explicitly forbidden (Bojko et al., 2013; Cohen, 2010; Samet, 2011). OST remains unavailable in Ukraine's CJS despite legislation that does not restrict its introduction (Izenberg et al., 2013). Recent policies mandate provision of OST in pre-trial detention centers to ensure continuity of addiction treatment, yet OST introduction has been hampered by multi-level organizational constraints that conspire to sabotage or delay it.

To better understand the reluctance of the Ukrainian CJS to introduce OST despite new laws allowing it, alongside the overwhelming evidence supporting its health benefits and improved criminal justice outcomes (Amato et al., 2005; Kermode et al., 2011), it is crucial to assess the prison personnel's attitudes towards OST. As there are virtually no data on prison staff attitudes and knowledge about OST in Ukraine, we conducted the first survey of Ukrainian prison administrative, medical and custodial staff attitudes towards addiction in general, OST, and PLWHA in four distinct regions of Ukraine. Findings from this study are intended to elucidate lingering biases and help direct future educational training programs and organizational interventions to address the barriers to implementing evidence-based HIV prevention treatments in FSU prison systems.

2. Materials and methods

2.1. Setting

Ukraine is Europe's second largest and seventh most populous country of 45 million, with diverse regional cultures and identities (Malik, 2013). To define the country's regions, we employ the standard four-region approach (Arel, 1995; Kubicek, 2000; Zaller et al., 2014) that divides the country into west, east, north/center, and south. Ukraine first introduced OST with buprenorphine in 2004 (Bruce et al., 2007), followed by methadone's introduction in 2007 (Lawrinson et al., 2008), which has since become the primary OST due to cost. Although OST reduces HIV risk behaviors (Altice et al., 2006; Metzger et al., 1993), increases ART access (Altice et al., 2011; Lucas et al., 2010; Uhlmann et al., 2010) and improves retention in HIV care and HIV treatment outcomes (Altice et al., 2011; Palepu et al., 2006), OST coverage in Ukraine remains inadequate, with only 2.6% of the estimated 310,000 PWIDs receiving treatment (Degenhardt et al., 2013; WHO, 2013; Zaller et al., 2014).

2.2. Recruitment and participants

As part of a nationally representative prisoner health survey (Azbel et al., 2013), three medium-security prison facilities were chosen in each of Ukraine's four regions for a total of 12 facilities. In each region, the 3 facilities were comprised of a first-time and a recidivist offender men's prison as well as a women's prison, representing the three types of non-specialized prison facilities in Ukraine. Trained research assistants approached all daytime prison personnel, the ones who would be primarily involved in OST delivery, and encouraged them to anonymously complete a brief pen and paper survey after providing informed consent; only three personnel refused participation.

2.3. Definitions

Due to confidentiality constraints, personal identifiers, such as age and gender, were not included. Region was decided *a priori* based on the city region (*oblast*'), where the study participant worked: east (Donetsk); west (Lviv); north (Kiev) and south (Odessa). Personnel position was defined by one of four categories: medical administration; custodial administration; medical staff; and custodial staff. Medical and custodial personnel were those members who worked directly with inmates on a daily basis. The amount of experience working in the CJS was included and categorized as: (1) <1 year; (2) 1–5 years; (3) 6–10 years; (4) 11–15 years; (5) 16–20 years; and (6) >20 years.

2.4. Measures

Knowledge about and attitudes toward OST was derived from a 16-item survey (Springer and Bruce, 2008), which uses a five-point Likert-type response where higher numbers reflect more positive attitudes. Principal component analysis with Varimax rotation suggested a two-factor solution for 16 items. The first factor

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