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Study on Assistance To Drug Users in Prisons

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Preface

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of 11 decentralised agencies set up by the European Union to carry out specialised technical or scientific work.

Established in 1993 and operational since 1995, the Centre's main goal is to provide 'objective, reliable and comparable information at a European level concerning drugs and drug addiction and their consequences'. Through the statistical, documentary and technical information it gathers, analyses and disseminates, the EMCDDA provides its audience – whether policy-makers, practitioners in the drugs field or European citizens – with an overall picture of the drug phenomenon in Europe.

At its Helsinki meeting in December 1999, the Council of Europe formally adopted the European Union Drugs Strategy (2000–2004). The strategy has been translated into concrete action on the third EU action plan on Drugs. The Plan recommends that the Commission and Member States joint efforts to reduce the crime linked to drugs, notably juvenile and urban delinquency. In this context is recommended to consider the EMCDDA activities into the law and proactive in the EU Member States on the treatment of drug users and drug addicts in the criminal justice system, including following arrest, alternatives to prison, and treatment facilities within the penal system.

Margareta Nilson

Introduction

Prisons are mostly overcrowded[1], stressful, hostile, and sometimes violent places, in which individuals coming from lower classes, ethnic and social minorities are overrepresented. Drug users and migrants belong to these groups in particular. Within the chain of law enforcement options that are available, imprisonment is a last resort. Generally prisoners learn about crime in prisons and often without realising that they become identified as prisoners and consequently recidivism is more the rule than an exception (Farbring 2000). Prison also affects health of the inmates: “Prisons are an area of special concern. We know that in most countries the lower socio-economic strata are over-represented in the prison population. We also know that prison is a very disadvantageous environment for good health: lack of privacy, stress, reduced opportunities for social support, hygiene, overpopulation, which all have a negative impact on health.“ (Goos 1997, 20). Consequently the WHO-consensus paper on „Mental Health Promotion in Prisons‘ is stating: „The WHO (Regional Office for Europe) Health in Prisons Project, aware that, in the absence of positive counter-measures, deprivation of freedom is intrinsically bad for mental health, and that imprisonment has the potential to cause significant mental harm ...“ (WHO 1998, 7).

In a European study on health problems arising in prison health, three main problem areas were highlighted: substance abuse, mental health and communicable diseases (Tomasevski 1992). These three problem areas are closely interrelated since the mid-eighties. Already in 1988 the WHO (1990) made an analysis of drug use in prison and developed recommendations for managing health problems of drug users in prisons. This basic effort had led in the following decade to a number of international co-operation and exchange of information and experiences in tackling drug users’ health problems in prisons.

Not only in European countries the number of prisoners has dramatically increased over the two last decades. Several factors contribute to that trend, like social developments of poverty, migration, violence and the politically accepted concept of incarceration and last but not least the widespread repressive legislation against drugs in the context of an increasing consumption.

Today, more than 8 million people are held in penal institutions throughout the world – more than half in just three countries; China and Russia each have over one million prisoners and The United States has over two million prisoners. The situation of drug use is reflected in these custodial settings: As outside drugs are used especially by deprived people in the prisons. The drug free prison is an illusion. Nowadays, daily prison routine is dictated by drug-dependent inmates. The Ministries of Justice and Public Health even go as far as making the assumption that the drug problem rocks the foundations of the penal rehabilitation system. Some comments are going as far as stating that the prison is ”totally dominated by a drugs culture embodied in prisoners‘ attitudes, values and behaviours” (O’Mahony 1997a, 42). Drugs are seen as one of the main problems of the current prison system in Europe and other states on the world. A study released in July 2000 by the Justice Policy Institute (JPI) reports that the United States has 458,000 of its citizens incarcerated on non-violent drug charges. This number of drug offenders that the U.S. imprisons is 100,000 more than the entire prison population of the European Union (356,000 incarcerated for all crimes combined), even though the EU has 100 million more citizens than the United States (JPI 2000). The high costs of incarceration are of great importance as well: The study reveals that a quarter of the amount Americans spend on prisons and jails in the year 2000 will be used to incarcerate non-violent drug offenders ($9.4 billion).

[1] see Council of Europe (2000)

Also in most European prisons the spread of drug use has become an essential problem. Some experts even say that prisons provide environments that sustain substance abuse among users and even foster drug use in nonusers (Rosenthal 2000) - there is some empirical evidence for that (European Network on HIV and Hepatitis Prevention in Prison 1998). Drugs are widespread, either used as addictive substance or to cope with the lack of work, stress and boredom behind bars, many prisoners report that drugs are the central currency in prison. Psychoactive substances seem to be easily available in many prisons, although the frequency of use differs from drug use in the community. Prison drug use brings its own dangers, apart from drug-related health risks, the possibility of violence and bullying for both prisoners and often their spouses and friends in the community (Turnbull/Stimson/Stillwell 1994).

Injection drug use in detention frequently leads to a spreading of communicable diseases like HIV/AIDS and/or Hepatitis B and C. A spread of these communicable diseases into the community is likely. In general drug using inmates suffer from a multiple drug dependency and show severe health damages, i.e. mental health problems or withdrawal symptoms, abscesses and infectious diseases etc. After release a high risk of overdose for drug users continuing their use exists.

But not only illegal drugs, but also legal drugs (nicotine/tobacco, alcohol, pharmaceutics) often contribute to the addiction and health problems of inmates. A study carried out in France in 1997 (N=8700 people newly admitted prisoners) reveals that 32% have a long history of regular use of illegal drugs, 33,5% declare excessive alcohol use and 13,5% of incoming prisoners are misusing alcohol and illegal drugs (Ministry of Justice 2000). Finally polyvalent drug use seems to be widespread in the drug using population in Europe.

According to estimates by the UN and WHO and information provided by EMCDDA REITOX Focal Points, drug users are overrepresented in prison populations throughout Europe. Although the figures given by various European countries widely differ, it can be assumed that approx. 15 - 90% of the 350,000 prison inmates in Europe use drugs or have used drugs in the past (lifetime prevalence of any illicit drug). Considering the high number of prison entrances and releases (turnover rate), 180,000 - 600,000 drug users go through the system annually. This fact inevitably affects life in European penal institutions. "There is probably no institution in society that has felt the influx of drugs have become a central theme, a dominating factor in the relationships between prisoners, as well as between prisoners and staff. Many of the security measures are aimed at controlling drug use and drug trafficking within the prison system" (Kingma/Goos 1997, 5).

PART I: METHODOLOGY AND DEFINITIONS

I.1. Methodology

The study adopted a research strategy, which included different methods to gain information. Existing written material about the topic from different kind and quality and additionally original data was collected and analysed. Together with the Trimbos – Institute/Utrecht(The Netherlands) a questionnaire has been developed and sent to prisons throughout Europe. Furthermore information has been collected from:

- prison services
- Ministries of Justice
- umbrella organisations in Europe (drug and HIV/AIDS service providers)
- prison visits
- international organisations and networks working in the field
- data bases (penlex/UK, EMCDDA)
- scientific or professional experts in the field
- literature review
- universities and archives (Archiv und Dokumentationszentrum für Drogenliteratur, Strafvollzugsarchiv, both situated in Bremen/Germany)
- data available from the (criminal justice system) information systems
- interviews with key figures, key representatives of the Ministries of Justice, or Health Inspectorates of the Correctional Institutions (these people received a letter with the aim of this study in advance).

The experience in the field of empirical work has shown that data and related assessments are not easily available from the ministries in charge. Therefore several supplementary activities had to be undertaken to get all the data required; different sources had to be addressed to obtain data and information on the relevant subject matters. However, it turned out to be difficult to obtain central data of the health status of prisoners, due to a lack of aggregated data. In countries which have a federalist structure and where responsibility of health matters in prison is in the hands of the Ministries of Justice, this seems even more difficult (e.g. Germany with 16 Ministries of Justice).

Proceeding from the principle of equivalence, namely that the health care measures successfully proven and applied outside prison should also be applied inside prison, the tasks to be tackled are presented from an inside/outside perspective. This means that the prison drug services are examined in the context of the national drug service structure and the drug policies pursued in all EU member states. This is the main approach which is applied at all levels of our analysis.

I.2. Definitions

The substantial differences in the estimated amount of drug users (shown in table 3) reflect the variety in definitions of the term ‘drug user’ in the prisons and prison administration in different EU-member states. Although all EU-countries report that drug users are a significant and extremely problematic part of the total prison population, only a few countries elaborated clear definitions of the term 'drug user'. As Turnbull/McSweeney (2000, 44) pointed out, none of the reporting countries of their Council of Europe

survey (23 out of 26 countries) "has a comprehensive system to quantify the scale of this problem, even though in most countries it is assumed that this group makes up a significant part of criminal justice and prison populations".

Often the definition is very generally focussing on length of drug use and type of drugs being used (Ekström et al. 1999, 8). Broad or even missing definitions make it extremely difficult to compare the situation of drug using prisoners in the different countries. Several questions arise and make comparisons difficult:

- Who is defining a 'drug user'? the doctor on admission (due to certain drug related symptoms like abscesses, puncture marks or positive urine testing) or staff member or prison administration or self-reported drug use (asked by whom)?
- What are the basics of the definition? Type of criminal offence committed laid down in the prisoner's personal file (violating the drug law and/or other laws in order to finance the drug use)?
- Which type of drug is meant? Illegal drugs: cannabis solely and/or opiates and/or cocaine, polyvalent drug use. Alcohol consumption for instance is mostly excluded in the definitions or not explicitly mentioned, although some recent figures (from France and Finland) show that about 1/3 - 2/3 of newly admissions declare an excessive use of alcohol, or have at least a history of alcohol abuse (Belgium).
- Which pattern of use is meant? Lifetime prevalence, drug use prior to incarceration (4 weeks, one year?), drug use within prison, occasional drug use, frequency, quantity, setting, problem drug use, polydrug use or supplementary use of pharmaceutics like benzodiazepine, barbiturates? Which route of administration (injecting, smoking, inhaling?)
- In which stage of the drug career (inmate with former drug use and treated resp. self-treatment and drug free or with longer period in the lifetime or in a beginning stage (juveniles)?
- What is the notion applied: occasional or addicted drug user?

Due to these heterogeneous definitions Muscat (2000, 10) suggests "...these figures (of drug using prisoners, H.S.) are dependent on the use of the term drug users ... and thus comparisons of such estimates should be viewed with caution."

Table 1: **Definition of drug user in prison**

Country	**Definition**	**Source**
Austria		
Belgium	Any user of sleeping pills, narcotics and other psychotropic substances that can create dependance and for which the user has no medical prescription	Ministry of Justice
Denmark	"Drug addicts are defined as persons who more than just a few times have taken one or more euphoriants within the last six months before incarceration"	Ministry of Justice 3rd July 2000
Finland		
France	“Regular use of drugs or of psychoactive medication, diverted from ist proper use, during the year preceding the date of imprisonment.”	Charlotte Trabut French Report to Pompidou Group 2000
Germany	“ 'drug addicted' is used as synonym for user of one or more drugs with a physical or psychological dependency potential”	State of North-Rhine Westfalia, Germany
Greece		
Ireland		
Italy		
Luxembourg		
Netherlands		
Portugal	Drug use by drug in use (both legal and illegal drugs included)	Machado Rodrigues, L. 2000, 6 (Table)
Spain	“suffer from problems related to the consumption of psychoactive substances”	Garzon Otamendi/Silvosa 2000, 90
Sweden	"The notion of drug misuse covers all forms of drug use without a medical prescription. Anyone known to have misused drugs during the twelve months prior to deprivation of liberty is classified as a drug misuser"	Ekström et al. 1999, 8
United Kingdom		

In some states/countries (e.g. Germany) the term 'drug addicted' is used as synonym for user of one or more drugs with a physical or psychological dependency potential. The prison governors ask for a report including the figures of drug addicts at every 31st of October, differentiated by users of illegal drugs, alcohol, pharmaceutics (Benzodiazepine) and others.

Drug addicted inmates are often perceived as polyvalent drug users, who use a variety of available drugs. In Northrhine-Westphalia/Germany for instance the medical examination at the entrance phase investigates whether a new inmate is drug addicted or not. This diagnosis is often completed by the internal drug counselling service to provide a precise recording.

PART II: DESCRIPTION OF THE SITUATION

II.1.Introduction

In summary it can be stated that the currently available data on the serostatus of prisoners do not yield transparent information with respect to the spread and dynamics of HIV and hepatitis infections. Only by considering additional data material[2] and by taking the varying objectives pursued and methodologies applied into account it will be possible to make epidemiological relevant statements on infectious diseases which are currently widely spread (hepatitis and HIV) and if necessary, to identify factors that affect the transmission or development of infectious diseases among the risk group of injection drug users in penal institutions.

This must not be mistaken for a plea in favour of an increased data collection or in favour of "compulsory testing" for research purposes. It is not the quantity but the quality of the serological data (longitudinal) that is important.

Helpful information needed for implementing adequate preventive measures may be obtained by identifying specifically risky modes of conduct in detention, the individual's readiness to use violence, his/her awareness of risks involved or his/her handling of risks. All this must be viewed against the background of the inmates' biographical records.

Finally it seems to be a consensus that those undergoing a test must benefit from follow-up medical consultation.

II.2. Prevalence of drug use among prisoners

There are different factors who might indicate the extent of drug use in prison. On the one hand there are scientifically acquired data: prevalence studies, which often reflect the present situation in often not more than one prison. Due to the heterogeneity of prison population from one prison to another in one region and in one country, these isolated cross-sectional studies can not be taken representatively for the situation as a whole: juvenile, women's prison, prison with lots of migrants may have totally different drug use prevalence figures. On the other hand there are documentation efforts: Several data can be added and centrally counted. In Sweden for instance, prisons write monthly reports on the extent to which drugs circulate in the prisons and drug misuse continues since 1991. "The information provided is based on the staff's knowledge of substances in use, the results of urine analyses, direct observation, etc. The extent of drug misuse is summarised using a five-point scale ranging from 'none' to 'virtually daily'. Although there are methodological weaknesses in the use of such a method, the findings have some value for assessing the extent of drug misuse in the prisons and following trends over a period" (Ekström et al. 1999, 11).

[2] Particularly studies of HIV/HBV/HCVseroprevalence in penal institutions focusing on social-scientific parameters like behavioural pattern and attitudes, and socio-demographic parameters, analysis of medical records, biographical records. Also, it must be considered if anonymously conducted studies of seroprevalence and follow-up examinations of inmates should be taken into account as well.

In the end it seems clear that the number of detainees under suspicion or sentenced under the Opium Act cannot be used as an indicator to estimate the size of the population. Most of the drug users sentences deal with traffic and/or trade offences.

The increase of drug users in the prison population can be noticed world wide: Hiller et al. (1999) report for the US that 68% of all new admissions are tested positive for an illegal drug in the urine screening.

The number of drug law offences in most of the EU countries have risen over the past 15 years (see EMCDDA figures from 1985 to 1998[3]). The number of prisoners in the 15 member states of the European Union is estimated to be 350,000, that means a ratio of 94 per 100,000 inhabitants - as compared with 645 in the USA (Rotily/Weilandt 1999, 144). Accordingly also the number of drug user in prisons has risen: ENDHASP (European Network of Drug and HIV/AIDS Services in Prison, 1995) estimated that 46,5% would be users of illegal drugs prior to imprisonment. According to EMCDDA (Annual Reports 1999 and 2000[4]), between 15 and 50% of prisoners in the European Union have or have had problems with illicit drug use.

How many drug users finally enter the prison system depends on the 'filters' that are applied before and during the contact with the different agencies of the criminal justice system (Alem/Wisselink/Groen 1999): “These filters are based on the legal rules and phases as well as priority setting by law enforcement agencies. In a great number of countries police and prosecution are formally obliged to bring to court any crime that is detected (‘legality principle'). In others the expediency principle (‘opportunity principle’) is applied which allows discretionary powers to the police and the prosecution”. Apart from these basic factors which of course influence the number of arrested drug users, other factors are important to mention:

- the degree of existence of alternatives to punishment developed at the stage of the court (strengthen the court’s existing powers in reviewing the offenders progress) before (suspend sentence in order to undergo treatment either in parallel with another community order or as a sentence in its own right) and during incarceration (either in prison or in outside therapeutic communities/institutions)
- the direct link between police arrest and referral to counselling agencies (e.g. ‘Arrest Referral’ in the UK, ‘Early Intervention’ in Germany and The Netherlands)
- different control measures which are merely not applied to drug users and affect the prison population: Krantz/Ekström (2000) argue that the high figure of drug users in prison (approx. 50%) has manifested itself since the introduction of intensive supervision with electronic monitoring (full scale in Sweden since 1997): “A prison sentence can be served at home combined with control of drugs and alcohol and participation in a personal change programme. Generally this option is open for non-drug users with short sentences. Electronic monitoring and other community sanctions has consequently reduced the proportion on non.-misusers in prison and increased the proportion of drug addicts”.
- the net of drug services which can suspend remand prisons because there is no reason for getting drug users in custody because they do have an address etc.

These filters determine the group of drug users which finally ends up in prison. A profile of this group would include the characteristics: highly socially deprived, often poly-drug users, with several stays in prison, several treatment attempts, high relapse experience, with severe health damages (including irreversible infectious diseases).

[3] See at http://www.emcdda.org/infopoint/publications/annrepstat_00_law.shtml

[4] See at http://www.emcdda.org/infopoint/publications/annrepstat_00_law.shtml

Looking solely at the drug related convictions and committals among prisoners largely underestimates the extent of the drug problem in the prison population. O'Mahony (1997) found in a study of a male prison population in Ireland that while 66% of the total sample (N=108) had a history of heroin use, only 6.9% were in prison as a result of a conviction for an offence against the Misuse of Drugs Acts (included a majority of drug trafficking-related offences). For Denmark it is reported that half of the drug users in prison in 1998 were imprisoned for 'general offences', i.e. other offences than violations of the drug laws (Focal Point Denmark Report 1998; confirmed for Italy by Italian Focal Point 1999). Another figure also seems interesting as an indicator for drug consumption: the people arrested by the police for drug-related use/possession. Research done by the University of Cambridge found in self-reported interviews and urine tests that nearly two thirds of the arrested showed some traces of drugs, which for most drugs means that they had been taken three days before arrest, 27% were tested for two or more drugs. The largest group were property offenders, they had the highest level of drugs in their urine (Bennett). Singleton et al. (1998,21) stated in their study on psychiatric morbidity among prisoners: "In general, both men and women held for burglary, robbery and theft had above average rates of drug dependence before coming to prison. The highest proportions reporting dependence were found among men held for burglary and women on remand for theft. Among these groups, over 70% reported some drug dependence and over 60% reported dependence on drugs other than cannabis."

It has to be kept in mind, looking at the following table that the figures represent inmates on any one day and not the total population during a year. This figure has to multiplied with the 'turn over rate' (all prisoners being in prison over one year in relation to the cross sectional data above) which is about 3 in the average of EU-countries. That means that the number of drug users per year in European prisons is two to three fold higher than indicated in the table below.

Table 2: **Prisons, Prisoners and Ratio per 1000.000**

Country	Total no. of prisons[3]	Total no. of prisoners (incl. Remand prisoners)	No. of fem. prisoners (%)	ratio per 100.000 inhabit. (total no. of inhabitants)	Date
Austria	29	6 973	406 (5,8%)	84	10/2000
Belgium	33	7536 male	331 female (4,4%)	78	31/12/98
Denmark	14	3477	177 (0,5%)	65	Average 1999
Finland	22	2 663	132 (5%)	56	31.12.99
France	185	52 122	1938 (3,7%)	90	1/7/2000
Germany	222	76 495	3473 (4,5%)	94 (80 Mio.)	31/3/2000
Greece	28 [1]	7 280 [1]	436 (6%)	51,0 [7]	
Ireland	18 [1]	2 983 [1]	80 (2,7 %) [7]	79 (3.786,000)	
Italy	220	51 604 [4]	2580 (5%)	90 (57 200 000)	
Luxembourg	2	380	22 (5,8%)	89,83	
Netherlands	39 [1]	12 553 1	564 (4,5%)	75	
Portugal	53	12,937	1,410 (9,7%)	147 (1998)	15/12/99
Spain		38,365 [5,6]	3523 (9,2%)	96,6 (39,7Mio.)	1.1.1999
Sweden	55	5,484	312 (5,7%)	61,8 (8 862 000)	1.10.2000
England/Wales	132 [1]	65,298 [1]	2 299 (4,1%) [7]	106,8 [7]	
Scotland	15	6.029	212 (3,5%)	118,0	1999

[1] according to Muscat 2000; [2] Koulierakis et al. 1999; [3] including all custodial establishments; [4] DAP – Justice Department; [5] not including Catalonia sovereign in this field, [6] according to statistics on the prison population of the Directorate General of Penitentiary Institutions; 7 1stSeptember 1996 (Council of Europe) 8 21st Nov. 2000

The highest prison population (per 100,000) is to be found in Portugal, Spain, England/Wales, Scotland, followed by Germany, France and Italy; however, the rate per inhabitant is lower in the Scandinavian countries e.g. Finland, Denmark, Sweden and Ireland. The average percentage of females in the prison population is located between 2.5 and 6 per cent with three exceptions (Spain 9,2% and Portugal 9,7%), where the female prison population is comparably high and Denmark with the lowest female prison population (0,5%). The Netherlands, Italy and France have the highest proportions of remand prisoners among their total prison population, 60.1, 45.5 and 38.7 per cent respectively. The proportion of prisoners with foreign nationality or other ethnic origin (as far as figures are available) is very high in all countries (average 18-20%), except for Ireland, above average of the migrant proportion in the general population. "This high proportion of migrants in prisons show clearly the need for improvement of group specific research and information for ethnic minorities and foreigners" (Rotily/Weilandt 1999).

Table 3 **Proportion of Drug Users among Prisoners**

Country	Proportion of drug users among prison population	Date of data	Remarks
Austria	10-20% [1, 14]	2000	10% drug related convictions; 14% in remand, 17,5% in penal institutions (estim. by prison doctors); 20% estim. by Ministry of Justice 10/2000)
Belgium	32%-42[1]	1/12/93	Todts et al. (1997) found a prevalence of 42% (n=1627)
Denmark	19% [15] – 36% [6, 8, 14,	1999	Nationwide survey. 25% of drug users are iv drug users. 49% of women`s population are drug users. Average age 30,6 years. 91% Danish,4%:Other European countries,5% countries outside Europe.
Finland	15,2% [9] – 31% [15]	1/5/1999	31% results of a survey by National Public Health Institute in 4 prisons, people reported having used drugs
France	32%	1997	Increase of drug users in prison from 10,6% in 1987 to 32% in 1997 (C. Trabut, Ministry of Justice 2000)
Germany	20-30% [11, 14, 18]	31/3/1999	In some women's prisons up to 70% Up to 50% of women's population is supposed to be drug user
Greece	26 [6] – 33%	1995	31% Injecting drug users in one prison (n=1183); 33,6% reported injecting drug use sometime in their lives in 10 correctional institutions randomly selected (n=861)
Ireland	30-52% [17]	1998	60-70% of women's population (Dooley 1998, 6); "About half of the total prison population is addicted to drugs" (Dr. Joe Barry, medical adviser to the National Drugs Strategy Team in Ireland, in: Irish Times 2000)
Italy	25%, [14] – 29% (15,097) [2]	31/12/99	
Luxembourg	36%	1/6/1999	

Netherlands	14-44%% [1, 14, 15]	1997/8	44% due to a survey in one prison (n= 319)
Portugal	37,7% [3]-70% [4; 10, 14]	31/12/98	10,7% foreigners in 1998
Spain incl. Catalonia	35% [15]-54%, [14, 15]		40% had consumed heroin or cocaine within the day of their arrest (Carrón 2000)
Sweden	47%	1.10.1999	Highest number of drug-misusing offenders since 1988/89: 5000 (53%) of all receptions in 1999
England/Wales	15-29% [1, 14]		i.v. use prior to incarceration. While in prison Singleton et al. (1998, 20) found that 19% of the male and 20% of the female sentenced prisoners used heroin.
Scotland	18-33% [1, 14]	1998	¼ is i.v. users, ¾ entering Scottish prisons test positive for drug use at the point of entry, compared to less than 20% of those already in prison (SPS 2000, 3)

[1] according to Muscat 2000

[2] Direzione Amministrazione Penitenziaria del Ministero di Grazia e Giustizia (DAP)/documentation

[3] all convicted cases for drug crimes (trafficking mainly) – N.B. This Table is on drug users and that figure is not (the only rates available refer to the 1989 Survey in all central prisons: men=46,48%; women=20,47%%, Machado Rodrigues et al. 1994, 1)

[4] Ministério da Justiça/DGSP/DSS – non scientific estimation

[5] not including Catalonia sovereign in this field

[6] Ministry of Justice (3rd July 2000)/documentation

[7] (Marinopoulou/Tsiboukly 2000, contribution to penlex database (Drugs, Prisons, and Treatment, see website address at the end of the report)

[8] Reventlow contribution to penlex Drugs, Prisons, and Treatment)

[9] Number of convicts sentenced for drug offences as their principal offence (Mäki 2000)

[10] Specific studies on the use of illegal drugs by prisoners (Rodrigues et al, 1994; Negreiros 1997) point out that about 40% reported hashish consumption, the same data appeared for heroin use before imprisonment (approx. 20% in prison)

[11] Federal Ministry of Justice/Ministry of Health 1995– non scientific estimation;

[12] Regular use of at least one drug (illegal drugs or medicines) during the year preceding incarceration, half of these were opiate user (Trabut 2000, 22)

[13] The number of female inmates is between 1,8% (Greece), 4% (NL), 5% (Germany), 5.7 % (Sweden) 9% Spain (except Catalonia)

[14] European Network on HIV/AIDS and Hepatitis Prevention in Prison

[15] quoted in Chloé Carpentier, EMCDDA paper not published (see at http://www.emcdda.org/infopoint/publications/annrepstat_00_law.shtml)

[16] Koulierakis et al. 1999

[17] Allwright et al. 1999

[18] 30% of 3600 male inmates at admission (73% of all female prisoners) in Baden-Württemberg were according to a study carried out by prison doctors supposed to be drug users in terms of need for counselling and/or therapy (Dolde 1995)

The figures differ widely, not only because of different prevalence of drug use in prison, but also due to the different definitions applied.

The prevalence of drug use varies extremely, mostly drug use is more widespread in:

- female than in male prisons[5]
- in city prisons than in prisons in the countryside
- juvenile than adult prisons
- prisons with high percentage of drug user/dealer near a border:

Drug use is illegal and disapproved of in the prisons, so the respondents who provided information about engaging in such behaviour could put themselves at risk of legal action by the authorities. The responses about drug use within the current sentence are often perceived by inmates as 'risky', responses are often given reluctantly because many prisoners fear disadvantages (fear of disciplinary action or even prosecution) for their current sentence. Therefore figures often have to be interpreted with caution. Additionally most drug using prisoners seek to hide their drug use career and history in order to avoid losing privileges or being subjected to extended controls of body, cell and visitors. This makes it even more difficult for doctors and medical staff to assess the drug using status of the inmate already at admission.

Finally there do exist only a few longitudinal studies. Mostly cross sectional data reflect the (drug using) situation at the beginning of incarceration. This leads to the fact that prevalence data can hardly be generalised and one has to be very careful in the use of these data. There is also a lack of qualitative data which might provide us with a deeper insight into the patterns and dynamics of intramural drug use.

II.3. What do we know about drug use in prison: drugs, patterns and frequency of use, routes of administration?

It is difficult to draw a detailed picture of the situation of drug use in prison, in one country and even more for the 15 EU-member states. Drug use in prison is taking place in an extreme secrecy and isolated factors like figures of seizure quantities, finding of needles/syringes, positive urine testing rates taken for its own only reflect one part of the situation. The patterns of drug use vary considerably between different groups in the prison population. For instance drug use among female prisoners is significantly different from men, with different levels and types of misuse and different motivations and behavioural consequences. Only collecting and collating several data will contribute to get an impression of the situation of drug use in prison.

Writing to Ministries of Justice with a questionnaire about drug related problems in prisons, the following answer has been received several times: 'First of all precise epidemiological data on drug use and drug related health problems in prisons do not exist. Information about health matters are not registered centrally, so I am not able to give you any figures about that. It is however evident that a great many inmates have psychiatric problems."

In the following information and study results about drug use in European prisons is briefly presented:

[5] Except Belgium where more woman are incarcerated for drug offences, but less drug use in female prison sections occurs

- The use of illegal drugs in prisons seems to be a long-standing phenomenon **dating back to the late seventies** (for France see Trabut 2000, 24), needle sharing at that time was extremely widespread (for Germany see Stöver 1994, 41ff).
- Some studies state that **the same substances available outside** are to be found inside with the same regional variations in patterns of use (see Trabut 2000, 24), some studies state that these drugs are often of a poor quality compared to that in the community.
- The prevalence of drug consumption varies **depending on the institution.** The phenomenon is more significant in large institutions and in short-stay prisons, more in women's prison than in men's prison, more in prisons in the near of a city than in prisons in the countryside (see also Trabut 2000, 24). De Maere (1999) found indications in his recent study that there is less drug use prevalence in remand prisons, because of the lack of organised trafficking networks.
- The most **commonly used drug** in prison is beside nicotine certainly cannabis for relaxation purposes. A Dutch study revealed that out of those using drugs during detention, 45% used cannabis (Bieleman et al. quoted in van Alem 1999, 8). Strang et al. found that in a sample out of 1,000 male prisoners 62% reported cannabis use in prison, 18% reported using injectable drugs in prison. Edgar and O'Donnell found even 76% claiming to have used drugs in prison, of whom virtually all had used cannabis at some time. But also heroin use does seem to play an important role among prisoners (Machado Rodrigues 2000 for Portugal; Todts et al 1997 for Belgium). Results of Mandatory Drug Testing in England and Wales reveals that in 1998 18,9% of the tested inmates used illegal drugs.
- Several empirical studies indicate that although the **number of drug users** is relatively high on entry, the use of drugs declines after imprisonment (for Portugal see Machado Rodrigues 2000), Spain, UK (see Muscat 2000). This may be due to the reduced supply of drugs or may also reflect the ability of drug using inmates to stop using drugs while in prison. Only a minority seems to use drugs and the preferred drug on a daily basis. Some studies indicate that half of the former drug users continue their drug use in prison.
- The basic question whether **prison influences the motivation to stop drug use** is answered by Muscat (2000, 14) as follows: "... prison on the whole does not motivate individuals to stop drug use ... in the ... countries reporting a reduced drug use within prison, this would appear to be unrelated to the motivation of the drug user to stop per se but rather is a consequence of reduced availability, lack of resources to procure drugs or the fear of detection". Whether these factors finally create a motivation to stop drug use is unclear. These factors outside often lead to inconvenient social life and are reported to be important to stop the habit mostly in the fourth decade of life.
- There might also be more **reasons for inmates to use drugs** while in prison: Trabut (2000, 25) states that some users describe a constant search for drugs to fight boredom and enduring prison, of dealing with the hardships of prison life, to overcome a crisis (bad news , conviction and sentencing, violence etc.) It seems that imprisonment delivers sometimes even more reasons for taking drugs or continuing the habit, or causes relapse after a period of withdrawal.
- **Lifetime prevalence of the use of illegal drugs (any)** prior to imprisonment is relatively high: i.e. 62,24% for men and 54,55% for women in Portugal (1989 Survey in all central prisons, Machado Rodrigues et al. 1994). A study of 1009 prisoners in 13 prisons in England and Wales revealed that three quarters had used cannabis at sometime during their life, more than a half had used opiates (mainly heroin) and/or stimulant drugs (amphetamines, cocaine and crack), 40% of them injected the drug(s). Lifetime prevalence of the use of illegal drugs (any) among prisoners in prison is less high: i.e. 48.46% for men and 20,47% for women in Portugal too.
- In some countries **alcohol** seems to play the major role or the second most commonly used drug (after cannabis, apart from nicotine, cf. Marshall et al. 1998) among people either admitted to prison or being already in prison. Recent figures (from France) show that 33,5% of newly admissions declare an excessive use of alcohol (more than 5 glasses per day and or 5 glasses consecutively at least once in a month (Ministry of Justice France 2000). Also in Belgium Todts et al. (1997) found in their study that

28% reported a history of alcohol abuse, for which 16% had already been treated. In some countries, alcohol seems to play the major role among people admitted to prison: According to a Finnish health survey from 1992 about 60% of the inmates were diagnosed as alcoholics and 13% were estimated to be drug users (Mäki 2000). Also for prisoners in England and Wales these figures can be found. Singleton et al. (1998) assessed harmful drinking patterns in 63% of male sentences prisoners and in 39% of female sentenced prisoners before entering prison. A Danish study published in 1990 (Kramp et al.) showed that 50% of the clientele – inmates and offenders under supervision - had abused alcohol, when the crime was committed, 25% had been treated for abuse of alcohol before incarceration and 33% were reported to be in need of treatment.

- Due to the scarcity of the preferred drug **changes in patterns of drug use** (volume and type of drug) are reported from many countries: the frequency of drug use decreases in relation to that in the community (Edmunds et al 1999). Those who continued to inject did it on irregular intervals and a reduced level (Meyenberg et al. 1999, Shewan 2000, Turnbull 2000, 101, figures indicate this also for Ireland), studies show that consumption of drugs while in prison seems to be significantly higher among injecting drug users than non injecting drug users (Trabut 2000, 24). In a UK-based study it turned out, that those who manage to inject on a daily basis are more likely to be imprisoned for a shorter period of time, often on remand and were held in a prison in, or close to their home town (Turnbull 1994). Other studies and observations of prison officers indicate that switching to alternative drugs (like from opiates to cannabis) or to any substitute drugs with psychotropic effects no matter how damaging this would be (illegal drugs and/or medicine) is widespread. Due to a lack of access to the preferred drug or due to sharp controls (like mandatory drug testing) some prisoners seem to switch from cannabis use to heroin (Edgar et al. see: Turnbull 2000, 99), because cannabis is deposed within the fatty tissue and may be detected up to 30 days after consumption or at least experiment with heroin.
- Drug use in prison may be characterised as follows:
  - high discontinuity in the availability of drugs, that means steady change of periods with withdrawal and consumption
  - quality, purity and concentration is even harder to calculate than outside
  - widespread poly-drug use to bridge periods of inability to finance drugs.

Despite the difficult prison circumstances some prisoners use the prison as an opportunity 'to **take a break,** to recover physically' (Trabut 2000, 26), or to stop using drugs in prison because of the threat of detection via drug testing (especially for those using cannabis). Often this time of abstinence is accompanied by a stabilisation of the general health status (increase of weight etc.). Furthermore a lot of drug users in prisons come from the more disadvantaged groups in society with low educational attainment, unemployment, physical or sexual abuse, relationship breakdown or mental disorder. Many of these prisoners never have had, or chosen to take up, access to health care and health promotion services before imprisonment. The medical services therefore offer an opportunity to improve their health and personal well-being (Goos 1999).

With respect to ceasing injections Turnbull (2000, 100) identifies several reasons:

- personal choice (including an assessment of the risks associated with injecting)
- practical (including the problem of acquiring drugs and needles and syringes)
- economic (the cost of drugs)
- decreased overall drug consumption).

- The percentage of those prisoners **continuing their use of injectable drugs** in prison is around 16% - 60% due to different studies in Europe[6] (overviews: Musacat 2000, 12; Turnbull 2000; 101, O'Mahony 1997; Rotily/Weilandt 1999; Koulierakis et al. 1999; Christensen 1999). A survey was carried out at local level in seven European countries in 1997 using a common methodology. It showed proportions of active intravenous drug users' '- defined as IDUs who have taken drugs within the 12 month prior imprisonment - among prisoners in 21 prisons ranging from 9% in France to 59% in Sweden, and 16 to 46 % in Belgium, Germany, Spain, Italy and Portugal[7].
- **Needle sharing and drug sharing** is widespread among prisoners who continue their injectable drug use. (Meyenberg et al. 1999; Rotily/Weilandt 1999): Although injecting drug users are less likely to inject whilst in prison[8], those who do inject in prison are more likely to share injecting equipment, and with a greater number of people[9]. Koulierakis et al. (1999) found in Greek penitentiaries that 50% of those reported injecting in prison shared their equipment with other prisoners. The EMCDDA (2000 Annual Report) reports a high prevalence of sharing injecting equipment within prison, which may reach 70% of the injectors in some prisons[10]. The Drug Misuse Statistics Scotland (1999, 126f) showed that five per cent of all prisoners reported injecting drugs in prison during the past six months and 4% reported sharing injecting equipment whilst in prison. The figure of 4% sharing is equivalent to 82% of injectors. The majority of inmates who are continuing their injectable drug use do this with used equipment. This was confirmed by the evaluation study of the first German pilot projects of needle exchange projects. Prisoners reported a nearly seven fold higher frequency of needle sharing in than outside prison (before the pilot scheme started). That means for many drug using inmates that they experience a relapse in hygienic injecting behaviour, because they were mostly used to an easy and anonymous access to sterile injection equipment outside. Some prisoners take even greater risks inside prison than outside. Allwright et al. found in their Irish national survey that 58% of injecting drug users in prison said they had shared all injection equipment (i.e. needles, syringes, filters, spoons) while in prison, compared to 37% that reported sharing in the month prior to being incarcerated, with serious health consequences: of those that had shared equipment inside prison, 89,1% had tested positive for hepatitis C, compared to 62,2% of those who had not shared in prison). These findings are conform to prison studies throughout the world[11] identifying injecting and the sharing of injecting equipment within prisons. In reporting on the first documented outbreak of HIV within a Scottish prison population in 1993, 43 per cent of inmates reported injecting within the prison – and all but one of these individuals had shared injecting equipment within the prison[12]. In an overview Turnbull is reviewing the empirical studies in the UK in respect to results on needle sharing. 62 to 100% of the respondents admitted having shared needles at least once while in prison. Turnbull et al. (1996) found that when considering other injecting equipment, more sharing occurred than was actually reported. Much re-use of equipment was viewed simply as "using old works". The sharing of "cookers" and "filters", and drug sharing by "backloading" and "frontloading" were common. The concept of "sharing"

[6] Results are consistent whatever is the methodology (ex-inmates or current inmates, face-to-face or autoquestionnaire, on remand or sentenced prisoners)

[7] European Network on HIV/AIDS and Hepatitis Prevention in Prisons

[8] Gill, Noone & Heptonstall

[9] Turnbull et al, 1994

[10] Sources:

- Multicentre study among prisoners, European network on HIV/AIDS and hepatitis prevention in prisons, Annual report to the EC, May 1998.
- Malliori, M., Sypsa, V., Psicogiou, M., Touloumi, G., Skoutelis, A., Tassopoulos, N. et al., A survey of blodborne viruses and associated risk behaviours in Greek prisons, Addiction 1998, 2(93): 243-251[*taken from* European network on HIV/AIDS and hepatitis prevention in prisons, Annual report to the EC, May 1998].
- Allwright, S., Barry, J., Bradley, F., Long, J. & Thornton, L., Hepatitis B, hepatitis C and HIV in Irish prisoners: Prevalence and risk, Dublin: The stationary Office, 1999 [*taken from* the 1999 National Report to the EMCDDA: Ireland].

[11] Covell *et al*. 1993; Turnbull, Dolan and Stimson, 1990; Carvell and Hart, 1990; Magura *et al*., 1993; Muller *et al.*, 1995

[12] Taylor et al. 1995

tended to be understood by respondents as relating to the tool of injection (needles and syringes rather than other equipment); the use of tools in the art of injection (rather than for mixing drugs); proximity (multiple use of needles and syringes in the presence of others); temporality (shorter time elapse between consecutive use of needles and syringes previously used by another) and source (hired rather than borrowed or bought). They conclude that syringe sharing is an integral part of drug use and drug injecting in prison. Many of those interviewed displayed a restricted understanding of what denotes syringe sharing. Our data reinforce the need for interventions and initiatives to be developed within prisons to deal with the considerable risk posed by continued injecting drug use.

- Figures from a European study and some national and single prison-based surveys indicate that the number of those **starting to inject while in prison** is ranging from 7%[13] to 24%. A recent national survey of Irish prisoners (N=1205) (Allwright et al. 1999) found that 20% (n=104) of those respondents who had a history of injecting drug use (n=506) reported that they had first injected drugs while in prison (see also Gore et al. 1995). Marshall et al (1998, 62) found in their prison survey 24% of those who used opiates reported their first time use in prison. Of 3,922 prisoners surveyed in 97/98 one per cent reported having injected for the first time while in prison (Department of Health 1999, see Turnbull 2000, 100). Few data are available on the percentage of those prisoners starting to use cannabis products for the first time in prison. According to Marshall et al. (1998, 62) 11% said that the first experience of using cannabis took place in a prison. De Maere (2000) found in an empirical study in Belgian prisons (autoquestionnaire) that 18,5% started to use cannabis while in prison, 6,5% heroin, 6% benzodiacepines, 4,5% cocaine (for Ireland see Ingle 1999).
- According to a French study some prisoners **discover new substances while in prison** (medicines, Subutex, see Trabut 2000, 24) or develop habits of mixing certain drugs they didn't take in that mixture outside. Although taken from a Bulgarian study (Nesheva/Lazarov 1999) the use of over-boiled tea and over-pressed coffee seems to be quite common in prisons: "Coffee and tea were available in the shops located in every prison: any prisoner could buy a certain quantity. Relatives visiting prisoners and sending them packages could give them coffee and tea. These two sources were 'legal,' permitted by the prisons' rules. The study revealed that there was also an illicit market for coffee and tea in the prisons. Those who used over-boiled tea and over-pressed coffee bought the ingredients at inflated prices from other prisoners. This exchange introduces a new elements into the general picture of inter-prison relations. A user could, for example, collect tea and coffee from the other prisoners as a payment for protecting them. The usual ways of preparing these two drugs were as follows: 50, 100, or 200g (or more) of tea was put in boiling water and boiling continued until there was a significant reduction of the liquid. The result was a dark brown, concentrated liquid above the tea leaves. Users usually drank this liquid, although it was suspected that some administered it intravenously. Fresh coffee, again 50, 100, 200g or more, was pressed several times or boiled as above. It was then drunk, although once more, some may have been injecting it. The above-mentioned quantities usually comprised one dose. There were two main ways of drinking: either all at once, or over 15 - 20 minutes. Although none of the interviewees reported injecting these substances, there was some anecdotal information that others did. The use of over-boiled tea was more common than the use of over-pressed coffee. The substances were usually used in the late afternoon or evening. There were cases of group use, but usually the users used these products alone. The effect of these products is stimulating, caused mainly by the caffeine extracted from them. Some sorts of tea contain up to 2-3 times more caffeine then the average coffee sample. The caffeine affects some brain structures responsible for the mediators metabolism and stimulates directly *formatio reticularis accendent,* which is responsible for the increasing tonus and vigility. The large quantity of caffeine also affects the vegetative neuro system. Other components of tea and coffee, such as theobromine (3,7 dimethylxanthin) and theophylline (1,3 dimethylxanthin) are alkaloids, and affect the cardio-vascular and respiratory system by stimulating the central neuro system. Taking into account the pharmaco-

[13] European network on HIV/AIDS and hepatitis prevention, Annual report to the European Commission, May 1998

dynamic aspects of the caffeine, theophylline and theobromine, some level of biological dependence is expected to develop.

- Due to a study including data of treated drug users in 23 European Cities (Pompidou Group 1999, 12) the classic picture of the injecting drug user is vanishing and smoking heroin ('chasing the dragoon') plays a significant role all over Europe. In some countries, where injecting is not widespread outside (i.e. Netherlands), this route of administration is also not widespread in prison. There have been some indications that users of injectable drugs turn to **alternative** (and risk reduced) **routes of administration** namely inhaling, smoking or sniffing (Greece, Spain). However, in other countries where injecting is the dominant route of administration outside, alternative ways are not applied in prisons, because they seem to be more expensive than injecting which is getting the maximum out of a minimal dosage of drugs (Meyenberg et al. 1999).
- There is a high **risk of acquiring communicable diseases** (esp. HIV/AIDS and Hepatitis) in prison for those continuing injectable drug use and obviously sharing needles and drugs: Several studies conducted outside penal institutions reveal that a strong correlation exists between previous detention and the spreading of the above infectious diseases (Kleiber 1991:35; Müller et al. 1995). Although intravenous drug use in prison seems to be less frequent than outside, each episode of IDU is far more dangerous that outside due to the lack of sterile injecting equipment on the one hand and high prevalences of sharing and an already widespread of infectious diseases.
- The **attitudes to drug use in prison** are indicating that certain drugs (in particular cannabis and benzodiazepines) are often regarded as serving a useful function or helping to alleviate the experience of incarceration. This is the result of the qualitative research among inmates and ex-inmates carried out by Marshall et al. (1998). "Many inmates seem to regard cannabis as essentially harmless. Alongside these attitudes, inmates recognise a need for treatment among those with serious drug problems and were aware of some of the health implications of injecting. They also displayed a possibly exaggerated concern about the problems of drug withdrawal. In the same study, prison officer staff shared many of these attitudes, some commenting on the uses of drugs as palliatives and the relative harmlessness of benzodiazepines and cannabis. Others were concerned about the development of a black market in drugs. In general, staff were acutely aware that the problem of drug misuse in prisons reflected a similar problem in the community" (Marshall et al. 1998, 62[14]). Some prison managers confirm the view that the use of some drugs in prison doesn't vary considerably from that outside. "We do still accept that prisoners who use cannabis are breaking the law and they will be treated accordingly, but we are reflecting the way world is outside prisons" (The Scotsman 13/5/98). The Howard League for Penal Reform in the UK is recommending in its 'Submission to the Home Affairs Select Committee' a depenalisation of cannabis within prisons[15] and the plea for cannabis being treated in the same way as alcohol, in that it should be primarily a health issue rather than a punishment issue.
- Many of the **drug users in prison had had no previous contact with drug services** before imprisonment despite the sometimes severity of their drug problems (Edmunds et al. 1999; Shewan/Davies 2000).
- **After release many drug injectors continue with their habit**. Turnbull/Dolan/Stimson (1991, 48; see also Edmunds et al. 1999) found in their study that 63% of those who injected before prison, injected again in the first three months after release. "Prison therefore cannot be seen as providing a short or longer term solution to individuals' problems with drugs".

[14] see also the study of Edgar/O'Donnell (1998) who confirmed that 82% of the inmates and 44% of the staff were in favour of tolerating cannabis use in prisons resp. didn't see any negative effects on discipline and order.

[15] see www.penlex.org.uk/pages/hldrug99.html

II.4 Drug use and drug related deaths after release from Prison

An English study found out that 86% of interviewed drug users report some form of drug use four months after release, so the impact of prison does not end at the time of release: The first two-weeks post-release is particularly dangerous, with death from drug overdose being eight to eighty times that of community levels[16]. A Finnish study published in 1998, found that post-release mortality was four times higher than a matched community cohort[17]. The conditions of imprisonment do not only influence the risk behaviour of drug users in prison but also drug-related mortality rates inside and outside prison: The risks which drug users are ready to take depend on the individual drug user´s consumption behaviour, on his/her physical and psycho-social constitution and on the conditions in the drug market. On the one hand the time spent in prison protects drug users against infections because in this environment drugs are sometimes hard to come by so that drug users are forced to do without drugs; on the other hand, however, the drug shortage in prison which induces consumers to be less cautious in drug consumption, increases the risks involved in drug use. Prisoners who have not taken drugs frequently during detention frequently find it difficult to adapt to the new situation after release; they return to old habits and consume drugs in pre-detention quantities. There are many reasons for returning to old habits: satisfaction, award, etc. The transition from life inside prison to the situation outside prison is an extremely sensitive period. Studies have shown that the risk of returning to pre-detention drug use after release rises according to the length of the prison sentence: The longer a drug user stayed in prison, the more difficult will it be to adapt to life outside prison. Even a prison sentence of only several weeks during which drug consumption was impossible poses a considerable risk to released drug users: Because of a reduced tolerance for opiates even small quantities are life-threatening.

In addition to this drug consumers are exposed to other major challenges after release: Frequently ex-prisoners feel the psycho-social consequences of detention; very many are faced with unemployment and have housing problems and disappointment with unfulfilled hopes is widespread. In many cases social relationships that existed before detention cannot be re-established so that contacts with people in the street are the only ones that seem no to have changed. Therefore ex-prisoners revert to these loose acquaintances after release.

Drug use after detention can be considered a means to compensate for the frustration which many released persons experience. However, to have again the possibility - after detention - to decide for oneself which quantity of drugs is consumed poses a great risk to ex-prisoners because they might feel that they have a lot to catch up on and as a consequence use too big quantities or take drugs at too short intervals. For many ex-prisoners getting into such a post-release situation is not a unique event because they have gone through this several times already: It is not a rare occurrence that 25-year-old prisoners have spent as many as 5 years on separate occasions behind bars already.

Frequently the transition from therapeutic measures offered in prison, e.g. methadone programs, to therapies monitored by a resident doctor outside prison is not fluid, i.e. released prisoners do not see a doctor within 24 hours after release or they are not informed about having to start a different therapy after release (e.g. if they have taken benzodiazepines in prison they need to change to a different drug). In the reverse case it can be stated that frequently an intact relationship between a participant in a methadone treatment and the doctor monitoring the therapy is interrupted when this person enters the prison system. As a consequence these prisoners relapse into chaotic drug consumption patterns in prison and after release (Seymour et al. 2000). So far reliable estimates of the extent to which drug-related therapeutic

16 Seaman SR, Brettle RP, Gore SM. Mortality from overdose among injecting drug users recently released from prison: database linkage study. Br Med J 1998; 316: 426-428.

17 In Australia the overall risk of death while in prison is twice that of a similar group of citizens in the community (Levy/Stöver 2000).

needs are satisfied in prison or of the extent to which prisoners participate in methadone programs or figures on the situation outside prison are not available for Europe.

Several studies and observations by police have shown that a large number of drug-related deaths occurred within a relatively short period after release. Strathclyde Police confirm that from 1996 to 1998, 21% of drug-related deaths in Glasgow were individuals released from prison less than 3 weeks. In 1999 24% of drug-related deaths were parolees out less than 2 weeks. An article in the British Medical Journal indicated that for HIV positive prisoners who inject, the risk of death from overdose in the 2 weeks after release from prison is substantially higher than at 10 weeks after release. For the rest, the chance that they will commit another crime without substantial assistance is higher still.

Despite the facts that a large number of drug-related deaths occurred within a relatively short period after release, it cannot be concluded that the prison sentence solely caused these deaths. An interplay of several other factors have to be considered: the length of time during which a prisoner used drugs prior to detention, his/her constitution, his/her readiness to take risks in drug consumption, his/her criminal record and the extent of time spent in prison.

On the one hand imprisonment means that drug users have to do without drugs for extended periods of time during which the risk of intoxication is low. Hence detention can be considered life prolonging. On the other hand there are those drug users who enter the prison system and are prepared to take great risks to consume drugs and who are not deterred by the danger of getting infected with a fatal disease.

A larger number of drug-related deaths after release must be attributed to the fact that those released return to pre-detention dosages without taking into account the periods of abstinence during detention and the resulting reduced tolerance for opiates. In many cases recently released drug consumers die of overdoses within the first few days after release: This finding was confirmed by studies in which data on recently released drug consumers were compared with those on drug users outside prison who were covered by the health care system. In the Swiss canton of Geneva autopsies revealed that 42 out of 102 released inmates (41%), died of intoxication within five years after release from prison (Harding- Pink and Fryc 1988). Within the first year after release 67% of released prisoners died of intoxication whereas only 22% died of other causes. 50 % of the intoxication-related deaths occurred within 45 days after release. They were due to the consumption of heroine/morphine, or methadone in combination with alcohol and benzodiazepines.

A Scottish study on the region of Strathclyde carried out between 1990 and 1997 revealed that 13% of all drug-related deaths occurred within one month after release from prison. 62% of these newly released died as early as in the first week after detention and as many as 22% died on the very day of release. Except for a few cases, which could not be cleared up toxicologically, death was caused by the consumption of an overdose of illegal drugs (in most cases heroine was consumed in the first few days after release and other drugs were used at later dates; Seymour et al. 2000). The findings were confirmed by studies on three German cities (cf. Heckmann et al. 1993): An analysis conducted by Püschel and Heinemann (2000) of the 1213 drug-related deaths that occurred in the city of Hamburg between 1990 and 1997 revealed that during the first 10 days after release the risk to die of opiate intoxication is extremely high.

Another study in which HIV-infected male drug users were analysed and which was conducted in Edinburgh/Scotland over a period of 12 years, also showed that during the first two weeks after release from custody the number of those released prisoners who died from intoxication was extremely high

compared to the weeks/ months that followed (Seaman et al. 1998). Compared to other causes of death the risk of dying from opiate consumption is 22 times higher.

The high rate of infection among imprisoned injection drug users has a long-term effect – also on drug-related death rates. As stated in chapter 2.4.1., there are indications that drug users were infected with HIV while in detention. However, infections with hepatitis B and particularly with hepatitis C are also rising at an alarming rate in prison. It is assumed that these infections end fatally within 10 to 20 years after infection. Moreover it must be assumed that despite less frequent drug injections in prison the number of "complications that occur during non-sterile drug injection e.g. phlegmons in soft parts, complications in venous and arterial vessels, alien element embolisms or inflammations of the heart valve is higher inside prison than outside prison. Occurrence of these complications in detention must not only be attributed to the use of insterile equipment for drug injection but also to the lack of preventive measures (including training on 'safer use') offered in prison. So far only virus-related HIV and hepatitis B/C infections have been studied in detail whereas the seriousness of long-term effects resulting from non-sterile drug injection in prison has not yet been studied in detail" (Püschel/ Heinemann 2000).

II.5 Infectious diseases in European Prisons

Generally rates of HIV, hepatitis infection and TB in inmate population are higher than the population as a whole. This is due to the high rate of drug users in prison and their bad health status.

II.5.1.HIV/AIDS

Whereas drastic changes in behaviour have been observed with a great number of injecting drug users, considerably many of them take great risks particularly in places where clean injection equipment is difficult to come by (Hamouda et al. 1996, 12). HIV/AIDS in prison is predominantly associated with iv drug users: They form the most important risk group for this disease. Prison presents a number of risk factors for the transmission of HIV disease, including:

- disproportionate number of inmates come from, and return to, backgrounds where the prevalence of HIV infection is high
- HIV may not be officially acknowledged by authorities so hindering efforts at education regarding safe practices
- activities such as intravenous drug use and unsafe sexual practices (consensual or otherwise) continue to occur in prison - restrictions on clean injecting equipment and condoms only aggravate this situation
- tattooing using non-sterilised equipment is present in some prisons[18], and
- epidemics of other sexually transmitted disease e.g. syphilis, coupled with their inadequate treatment, encourage transmission of HIV.

According to the Annual Report (2000) of the EMCDDA, the number of AIDS cases is decreasing in several countries (France, Italy, Spain) only in Portugal is increasing as well as the figures are for HIV in

[18] In Canada for instance according to the CSC 45% of federal inmates reported having had a tattoo done in prison. Turnbull/Dolan/Stimson (1991, 50) report that 26 of their respondents have done their tattoo done on the last occasion they were in prison. 13 of those said they shared the tattooing equipment.

Finland. But in two thirds of the EU-countries prevalence of HIV infections among drug users is lower than 5%, in the UK even less than 1%.

Assessing the specific risk factors for HIV infection among inmates data from a study[19] carried out in 25 European prisons in 1996-98 (Weilandt 2000, see also Rotily/Weilandt 1999) found a HIV prevalence of 5.7%, significantly higher in Portuguese (19.7%) and Spanish (12,9%) prisons. It was also higher among intravenous drug users. For intravenous drug using prisoners, the authors showed that HIV infection was significantly related to drug injection in prison after adjustment for age, sex, country, year of first injection, and number of incarcerations; however, among IDU who had ever injected in prison, after adjustment for confounding factors, HIV infection was not significantly related to needle-sharing in prison. Among non-i.v. drug using prisoners logistic regression showed that, after adjustment for age, sex, and number of incarcerations, HIV infection was independently related to homosexual intercourse and sex with an IDU before incarceration, but not to homo- or heterosexual intercourse in prison.

Rotily et al. (1994) found that the HIV seroprevalences were 6 times higher among prisoners who have already been incarcerated than among prisoners incarcerated for the first time.

In some countries HIV seroprevalence rates among prisoners and especially among drug using prisoners are still increasing. Heinemann (2000) examined HIV tests in the state of Hamburg/Germany from 1991-1997. More than 50,000 prisoners have been tested. “The overall HIV seroprevalence in prison was 1.5% with a steady increase from 1.1% (1993) to 1.9% (1997). Among IVDU inmates the prevalence has increased since 1993, from 2.1% to 6.3% (1997)”.

Several studies conducted outside German penal institutions reveal furthermore that a strong correlation exists between previous detention and the spreading of the above infectious diseases (Kleiber 1991:35; Müller et al. 1995). In their study Stark/Müller (1994, 2) point out that "with those persons who frequently used the syringes of other inmates during detention, the risk to get infected with HIV is more than 10 times greater than with those who have never been in prison. 50 % of addicts who had used the syringes of other inmates more than 50 times were HIV infected and 97 % of them were infected with the hepatitis C virus. By contrast, with those who had never been in custody the infection rates only reached levels of 5 % and 71 % respectively". Kleiber (1991:35) also established a connection between detention and the spreading of HIV infections: In his epidemiological study of HIV prevalence among drug users (n = 1253) he found a correlation rate of 19.9 %. Further analysis revealed that 10 % of drug users without experience of detention (n = 499) were HIV-antibody- positive. With those who had been in prison the rate was 26 %. Of the interviewees who also stated that they had consumed injectable drugs during detention, 33.7 % were HIV positive. The more often addicts have been in prison the more likely is it that they get infected with HIV. This became most strikingly apparent with the women surveyed: "More than 40 % of the female users of injectable drugs who had been in prison more than 3 times were HIV-infected. This finding most clearly reveals the correlation between HIV infection and another variable" (Kleiber 1995, 16). Koch/Ehrenberg (1992, 48) confirmed these results. Their survey of 660 people revealed that with injection drug users who had been in prison HIV prevalence was almost twice as high (23.7 %) as with those consumers of these drugs who had never been in custody (12.5 %).

The proportion of female inmates with HIV is more than 30 times higher than the proportion of HIV infected women in general population (i.e. 3.5% in US prisons). Several experts indicate an increasing trend in HIV-infection in female prisoners (Garzon Otamendi/Silvosa 2000, 88)

[19] This study was carried out in 25 European prisons in Belgium, France, Germany, Italy, Portugal, Spain and Sweden in 1996-98. Prisoners were invited to fill an anonymous and self administered questionnaire and to give a saliva sample for HIV testing.

A strong evidence of the risk of HIV/hepatitis transmission in prison is the HIV outbreak[20] which happened in a Scottish prison (Taylor et al. 1995). This study was carried out in response to an outbreak of acute hepatitis B and two seroconversions to HIV infection. Evidence based on sequential results and time of entry into prison indicated that eight transmissions definitely occurred within prison in the first half of 1993. However, well-documented outbreaks of HIV infection or viral hepatitis are exceptional. They are ignored by national surveillance centres, for the simple reason that a history of recent incarceration (and where) is not routinely documented in all cases of HIV or Viral Hepatitis (Gore and Bird, 1998). Using existing data on hepatitis C prevalence, injection-related hepatitis C transmission and needle use in Scottish prisons and new data on infectiousness, Gore and Bird (1998) estimated that a study including 3000 prisoners followed up for 10 weeks would expect to detect about six hepatitis C seroconversions, even with conservative estimates of injection frequency and transmission rate. Such studies the design of which deserves to be worked out considering both operational and ethical aspects, should be carried out in a near future.

II.5.2. Hepatitis B/C

Already in 1968 an examination of federal prisoners in America has revealed an unexpectedly high incidence of hepatomegaly, sometimes accompanied by abnormal liver functions. The researcher found a clear correlation between 'sharing hypodermic equipment' and suffering from 'a long-term form of serum hepatitis' (Sapira/Jasinski/Gorodetzky 1968). In the nineties a general awareness of the spread of hepatitis has been raised and the results of the Amercian study have been confirmed that Hepatitis B and C are strongly associated with injecting drug use (Reaper et al. 2000) - hepatitis C is even seen as a typical prison infectious disease. Hepatitis B+C pose an even greater problem than HIV-infections to drug using inmates. Because of high turn over rates, screening and vaccination for Hep. B often remains incomplete.

Outside prisons the number of hepatitis infections among injection drug users has risen considerably, despite the provision of infection-preventive aids. In part this is due to the fact that hepatitis viruses are much more resistant to environmental influence and thus are much more easily communicable than for instance the HIV-virus. However, the high prevalence may also be attributed to the lack of hygiene among certain consumers of drugs when injecting drugs intravenously: Either they share needles or injection equipment and drugs respectively.

Finally the epidemiological conditions must also be taken into account. The number of hepatitis-infected drug users is very high. The risk of getting infected by handling injection equipment carelessly or by not exercising proper care is extremely high. Heinemann (2000) examined a large number of tests on viral infections of prisoners in Hamburg (50,000 between 1991-1997) and found a prevalence of Hepatitis B in the overall prison population of 38% and 65% for i.v. drug users. There was an increase in Hepatitis C from 24% (overall) and 77% for i.v. drug users in 1997.

In a survey conducted in the prison of Wolfenbüttel/Germany, Gaube et al. (1993) found that the rate of hepatitis A, B and C infections was 100-200 times higher among prison inmates than among average citizens. However, these figures reflect the epidemiological situation of the convicts at the beginning of their prison sentence. The finding that hepatitis infections occur much more frequently in detention is supported by a study conducted by Keppler/Nolte/Stöver (1996, 104) in the women's prison in Vechta, Lower Saxony: 78 % of the drug-consuming women were infected with hepatitis B and 74,8 % of them were infected with hepatitis C. Furthermore the authors found that the number of seroconversions during

[20] See also 'Outbreak of HIV Infection in an Australian Prison' in: Canadian HIV/AIDS Legal Network, (fact sheet 3)

detention was considerable: 20 out of the 41 women with seroconversions (i.e. 48.8 %) had been infected with hepatitis during detention.

The efforts undertaken to prevent infectious diseases should not be restricted to reduce the spreading of HIV but should also be designed to reduce the risk of getting infected with hepatitis, particularly with injection drug users in detention. With regard to HCV different prevention strategies have to be developed in contrast to HIV/AIDS reflecting especially 'household' transmission and sharing of equipment, drugs water etc.

Table 4 gives an overview of antibody positive rates of various infectious diseases in prisons of EU-countries taken from several sources:

Table 4: **Infectious diseases among prisoners**

Country	HIV	Hepatitis B	Hepatitis C	Source
Austria	1% [1]	21,7% men, 15,9% women [2]	women 20-30%, men 20% [2]	[1] Ministry of Justice, 2/2000; [2] Spirig et al. 1999
Belgium	0.3% [2]-1.2%[4]	2.2%[2]-7.7%[3]	17.4%[2]-28%[3]	[2]Prison of Brugge – prison hospital[21] [3] Ministry of Justice; [4] Prison of Lantin[22]
Denmark	No data	IDUs64,3% non-IDUs 13,5%	IDUs 87,1% non-IDUs 9,7%	Christensen et al. European Journal of epidemiology (in press)
Finland				
France	2,2 [7]	1,3% men [5] 11,5% women [6]	25,6% [5]	[5] M. Rotily 1997/Vernay-Vaisse, [6] Maison d'arret de femmes de Fleury-Meorgis, Dr. Khodja [7] European Network on HIV/Hepatitis Prevention in Prisons
Germany	0,12-2,8% men; 0,48-8% women	no data	no data	Ministry of Health/Ministry of Justice 1995
Ireland	2%	9%	37% (80% [8])	Allwright et al. 1998; [8] drug addicts only (Dr. J. Barry in: Irish Times 2000)
Italy	3,25 % (1546)			Italian Focal Point
Luxembourg	0,8% (2 cases from 250)	28% (70/250)	27,7% (69/250)	Reuland/Schlink 2000
rtugal	11%,[9] - 16,7% [10]	25% (hep. B+C) [9]		[9] Machado Rodrigues (2000) [10] European Network on HIV/Hepatitis Prevention in Prisons
Spain	19,9% [11]	45,6% [12]	46,1% [13]	[11] HIV among IDU 46,5%, [12] HBV among IDU 71,4%, [13] HCV among IDU 89% (Carrón 2000)
Sweden	0,5% (19 of 3,537) [14]	54% all; 52% men; 73% women [15]		[14] Kriminalvarden, Swedish Prison and Probation Administration (18.12.2000); [15] Kerstin Kall
England/Wales	0,32% (9 of 2813) male/1,2% (5 of 410) female adult prisoners			Department of Health 1997 anonymous survey (NHPIS 1999)

[21] Prison of Brugge – prison hospital (Flemish community) year 1999 _ sample size : HCV: 321; HBV=314; HIV=316) criteria: any patient admitted in the hospital

[22] Prison of Lantin (French Community of Belgium) year 1999 –samples size: HCV : 692; HBV = 668;HIV= 668 – inclusion criteria: any prisonner asking for a test.

II.5.3.Tuberculosis

Prisons have been identified as reservoirs of tuberculosis, although there are limited data to support this contention. Where data are available, they reveal higher levels of active disease reported from prison populations as compared to that for civilian populations. Carrón (2000) reports for the situation in Spanish prisons a rate of 50% TB-positiv inmates, among these 55% are supposed to be i.v. drug users. Reasons for high prevalence of tuberculosis among prisoners are that prisons promote transmission of tuberculosis infection due to late case detection, lack of respiratory isolation and inadequate treatment, high turnover of detainees through repeated transfers within the prison system, overcrowding and poor ventilation. A disproportionate number of detainees are derived from population groups already at high risk of tuberculosis infection and disease, e.g. those addicted to alcohol, illicit drugs, the homeless and the mentally ill. These populations often have poor access to adequate treatment in civilian life. HIV is the most potent risk factor for the development of active tuberculosis disease in previously infected individuals.

Where HIV co-exists with tuberculosis infection, the annual risk of development of tuberculosis disease is between five and 15 percent, as opposed to the estimated 10 percent lifetime risk for those uninfected with HIV. Where rates of HIV in civilian and detained populations have been compared, up to 75-fold increases in prevalence have been reported (see Levy 2000).

II.6. Specific target groups: women, migrants and young offenders

Treatment efforts are mainly addressed at adult, male prisoners with origin in their countries. Specific needs of certain groups like juveniles, women, migrants and other minorities are often neglected because of their small number. Interventions should also be designed to these prison population groups with a better tuning to ensure that appropriate treatment is provided.

II.6.1. Women

Criminality seems to a wide extent a male problem, women on the average only represent approx. 5% of the inmates in European prisons (ranging from 1,8% of the total prison population in Greece, 3%, in The Netherlands, 5% in Germany, 5,7 % in Sweden and 9,2% in Spain (except Catalonia). Some countries indicate that the number of imprisoned women has risen considerably over the past decade. In Spain from 1987 to 1999 the number doubled. In England and Wales this process happened only in a six years period. The English Home Office report ‘Women and the Criminal Justice System’ of the year 2000 (see The Guardian 13th of December 2000) says that women tend to have shorter criminal histories than men and ‘grow out’ of crime earlier, but were more likely to be arrested for less serious offences. The reasons for incarceration are shop lifting and other forms of minor theft. The report reveals also that 55% of the imprisoned women do have children under the age of 16 and more than a third has a child under the age of five. These figures indicate that the average time of imprisonment is very short, family problems are severe, poor educational level, bad work situation and the drug problem is overwhelmingly the central issue of imprisoned women. On release an English survey of released female prisoners found only 25% were in employment when interviewed five to nine months after discharge. These variables must be taken into account in the planning and the design of intervention strategies in and after imprisonment.

The incarceration for female prisoners is organised differently in the EU states. In some countries there are only separated units for women and/or there are specific women's prisons. As there are only small numbers of female prisoners, often there does exist only one institution for a bigger regional area (e.g. for one of the German 'Länder', Women's Prison Vechta/Lower Saxony, or a bigger region like London/UK 'HMP Holloway'). That causes particular problems for incarcerated women to stay in contact with their children, families, relatives, partners and social relations at home.

Maybe due to the fact of small numbers, data on female prisoners especially female drug using prisoners are hard to achieve, most studies have been conducted on male subjects[23]. Information on addiction and risk behaviour have often been extrapolated from research on male incarcerated populations: "This has not only led to a lack of information on the specific situation of women, but also fostered a bias, whereby men's addiction is treated as the standard by which women's addiction is measured" (Guyon et al. 1999, 50).

There are severe health problems of female prisoners that need specific attention: The rate of HIV infection rate among female prisoners is according to several studies and estimations higher than among incarcerated men[24]. In Germany at two different dates 31. December 1993 and 31. March 1994 the rate for HIV-positive men was 0,12%-2,8% and the rate of the female prisoners was 0,48%-8%; Federal Ministry of Health 1995, 6). The percentage of drug using women in prison is very high in most of the EU countries. In some countries data suggest that two-thirds of women entering prison report a history of severe drug and/or alcohol use prior to imprisonment, poly-drug use is a widespread pattern of use, although some information indicate that drug use in prison seems to be at a lower level than for men (see 'Prison Service Drug Strategy' England/Wales). The reasons for the higher prevalence of HIV infection are discussed as follows.

One explanation for that gives Pant (2000, 204ff) from the biggest epidemiological study on HIV prevalence in Germany. One half to three quarter of the drug using women earn their money for drugs by prostitution (against 10% of the men). HIV prevalence among female prostitutes was two-three times higher than for women without a prostitute activity. Although it seems unrealistic and epidemiologically not proven that women acquire HIV from their heterosexual suitors, it seems that 'prostitution' is a 'behavioural marker' for a high co-morbidity with sexual transmitted diseases and hepatitis infections, a high level of everyday stressors, and a higher level of drug use (cocaine, pharmaceuticals etc.). Pant supposes that the immuno-competency of drug prostitutes is reduced and the susceptibility in case of HIV-exposition is increased. Another supposition is that women in order to compensate the experiences of prostitution do have a more 'chaotic' and higher degree of mixed drug use and are exposed to more risks to acquire HIV-infections via used needles/syringes or contaminated equipment. Apart from that unprotected sexual contacts in private relations result in a higher risk exposition than men. And finally women seem to start earlier taking drugs (Guyon et al. 1999, Zimmer-Höfler et al. 1992).

In some institutions the high demand of women who need detoxification represents a big problem. Also the misuse of prescribed drugs is a major threat. But not only misuse, also the amount of legally prescribed drugs forms a health problem in some countries: It is said that for some countries (England and Wales, France, Germany) that there is a widespread use of psychoactive medication in particular by women, prescribed by prison doctors. In Scotland 97% of the female prisoner population is receiving some form of medication (commonly for patterns of mental disorder). The prescription practice inside prison only reflects the situation outside. In France for instance anti-depression medicine, hypnotique and

[23] This reflects also the situation outside: gender-related differences are also uncommon, because women often represent only one quarter of the drug scene

[24] see with an overview Guyon et al. 1999

psychotropic substances are widely used in the general population, so the prison situation is not different from that (Khodja 2001). Risks of becoming dependent from these substances during and after imprisonment are not impossible.

Drug-addicted women in prisons are exposed to physical and emotional strain: They try to cope with prostitution, emotional, physical sexual abuse and violence by consuming intoxicating drugs (see Antonietti/Alberto 1997). This mode of behaviour, i.e. to try to solve a problem inwardly or even to blame oneself for it, is typical for women. "Victimisation has many implications for women in general, but perhaps particularly for those in custody. Increased substance abuse is one possibility. Vulnerability during withdrawal from drugs or alcohol is another problem and women are particularly vulnerable during the first few days and weeks in custody. Feelings of shame, isolation or self-blame, which in turn reduce their self-esteem, are not uncommon. This is particularly true of women who have been victims of abuse, when even standard prison procedures such as body or cell searches, and the loss of autonomy which is a basic part of prison life can trigger feelings of helplessness and frustration reminiscent of the experience of abuse itself." (SPS 2000b, 35).

It becomes apparent that due to the short term sentences of female drug using inmates gender specific assistance to this group is centred around topics of motherhood (care for pregnant drug users and impact on unborn child) and women specific medical needs (special medical support for gynaecological examinations and cure etc.). The separation of women from their families, relatives and from their children constitutes a specific form of social exclusion, which needs to be tackled.

Problems of sexual abuse, rape and violence often cannot be targeted within the prison setting, because adequate help cannot be provided. The Scottish Prison Service for example doesn't consider it as appropriate to commence work to address sexual abuse in the prison setting for remand and short-term prisoners. "While support should be provided for those who seek help, disclosure work is not thought advisable as the accompanying distress may be difficult to manage within the constraints of a custodial sentence" (SPS 2000b, 35). Therefore voluntary organisations should be encouraged to offer appropriate help in the community after release.

In addition, however, there is a growing need for new initiatives[25] that acknowledge that the problems encountered by female inmates in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. The task of protecting women prisoners from HIV and hepatitis transmission therefore presents different – and sometimes greater – challenges than that of preventing HIV infection in male prisoners.

Underlying many of the problems that women in prison encounter is the fact that "[t]he majority of women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, sexual orientation, disability, substance use, and/or occupation as sex workers" (Canadian HIV/AIDS Legal Network). Female inmates often have more health problems than male inmates. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care. Many HIV-positive women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-positive men. Among the reasons for this is that women are often unaware of having been exposed to HIV by their sexual or drug-using partners and as a result do not seek counselling, HIV testing, and care and treatment. Second, the needs of HIV-positive women differ from those of men, and social and community support are often less frequently available and less accessible. As a consequence,

[25] e.g. the Home Office in the United Kingdom is looking to set up a new think-tank to consider how to represent better women's interests in the Criminal Justice System (News Release 12/12/2000).

women are often less educated than men about HIV infection and AIDS and do not have the support structures they need. For these reasons, the educational needs of women prisoners regarding HIV/AIDS are different from the needs of male prisoners and the need for HIV prevention programs in women's prisons may be even more pressing than in men's prisons.

One step into the direction of improved services for women is the installation of a particular Woman's Health Clinic (like in Holloway/London). Here a full-time Health adviser is employed. Her role entails giving sexual advice to women in the clinic, partner notification in line with Health Adviser guidelines, pre and post test discussion for HIV and Hepatitis C, and counselling for related areas such as HIV, sexual assault, and terminations. The Health Adviser co-ordinates the Through-care of her clients to ensure that prisoners have access to services inside and after release. She facilitates visits from organisations such as Positively Women and may attend outside hospital appointments with clients for support. The Health Adviser is involved in prisoner education in the areas of Harm-minimisation and Sexual health.

II.6.2.Migrants

The high proportion of migrants in the prison population in most of the European countries (compared to the general population) shows clearly the need for improvement of groups-specific information for ethnic minorities and foreigners. Account should be taken to the different backgrounds and different individual native languages.

II.6.3.Young offenders

Young offenders are those aged between 16-21 years are treated differently from adults in special units and institutions. Educational efforts focus on a prevention of persistence of offending behaviour and drug use for the drug using population and assisting them in schooling and qualification measures. The drug using patterns may be different from the adult ones both in the community and in prison. Keppler (2000) in his epidemiological work found extremely high risk patterns and sero-conversions (Hepatitis B and C) among young offenders. Many prison experts confirm this pattern, they report an often less cautious dealing with drug use incorporating higher risks in injectable drug use. This may be due to feeling of inviolability. This behaviour becomes extremely important in the prophylaxis of blood-borne viruses. But more generally in many countries there are attempts to help young inmates to resist drug misuse in order to achieve their full potential in society. The work is often closely linked to the work of the community based drugs initiatives. Peer driven approaches are widespread, because peer groups seem to be the major group in which cultural and ritual patterns are learned and persisted (see chapter 3.5.1.2.).

Especially the regimes for young people in custody lack of a harm reduction approach. Abstinence oriented work is the predominantly access to this group, although there are some exceptions (like integrating this group into needle exchange in the women's prison of Vechta/Germany).

PART III: DESCRIPTION OF THE RESPONSES

III.1. Introduction

The increasing use of drugs changes life in prison: the penal system as a whole changes, the behaviour of drug users in detention changes and drug service providers are faced with new demands. Prisons reflect social and individual problems. Thus the rising spread of illegal drug consumption outside prisons and the implications arising from it may also be observed in prisons: drug-related deaths, drug-induced cases of emergency, increase in the number of drug users, dealer hierarchies, debts, mixed drugs or drugs of poor quality, the purity of which is incalculable and risks of infection (HIV and hepatitis) resulting from the fact that no sterile syringes are available in detention and therefore contaminated injection equipment is shared.

This increase in drug consumption entails also major implications for the penal system: drugs become the central medium and currency in prison subcultures: Many routine activities of inmates focus on the acquisition, smuggling, consumption, sale and financing of drugs. If the acquisition and the use of drugs dominate the life of prison inmates, prison directors and staff have to make increased efforts to safeguard a regular course of prison sentences. This is the primary goal to be achieved. Solving the problem of drug addiction in detention is secondary.

Prison management are faced with increased public pressure to keep prisons drug-free. This affects all forms of detention for men and women: punitive detention, pre-trial detention, detention of juveniles. Only a small number of prison managers talk frankly about the issue in public and establish adequate drug services and develop new drug strategies. Frequently, however, confessing that drug use also appears in prison, is to be mistaken for failing to maintain security in prisons: the prison system which is supposed to be impenetrable for drug trafficking, has turned out to be penetrable. The number of prison managers who deny or ignore drug use in prison for political reasons is still great. Additionally many prison doctors believe that they cure the inmate's drug problem, when an inmates is temporarily obliged to stop using his drug habit. Before this background it becomes obvious why the dealing with addicts in detention is difficult: on the one hand the goal to achieve the convicts´ rehabilitation[26] must be pursued; on the other hand prison management are faced in many countries with rising drug consumption among inmates and with political and economic restrictions which make it even more difficult to solve the drug problem.

The current situation in which judicial authorities find themselves is paradoxical: they have to find a solution to a problem, which is not supposed to exist: Drugs should be kept out of the prison. The situation in prisons can be compared to the one outside prisons ten to fifteen years ago. However, in the meantime the attitude of society towards illegal drugs has changed: Terms like acceptance, tolerance and indifference may be used for describing this attitude. After 10 years directors of penal institutions have realised that they cannot avoid adapting to the new situation: in some prisons (e.g. in North Germany) urine tests do not include testing for cannabis consumption anymore. As regards the attitude to be taken towards consumers of opiates, a widely held view is that "actually" they do not belong in prison. Drug addiction is unanimously perceived as an illness, which cannot be treated adequately within the prison setting. Just like their counterparts outside prison they should be given the opportunity of undergoing an adequate treatment.

[26] e.g. as stipulated in the Prison Act: §3, para 1 stipulates that living conditions in detention must be adjusted to those outside prison, as far as this is possible. On the other hand the demand to provide adequate aid for drug addicted inmates must also be met. §3, para 2 of the Prison Act stipulates that harmful impacts of detention must be counteracted. This also means that any form of drug consumption or increase in drug use is contrary to the original goal to be achieved through imprisonment.

III.2. Organisation and practice of health care and assistance provided to drug users in prisons

Coping with drug use in prison is difficult for several reasons: drug use is illegal, it leads to harsh consequences for the time staying in prison: loss of privileges, (i.e. home leave), segregation, higher control frequencies (i.e. cell searches), discrimination by non-drug using prisoner (fear of transmission of infectious diseases) etc. The primary goal of correctional institutions is to provide safety, humanity and cost-effectiveness. Humanity of course includes offers of help for all inmates including the group of drug users. But for them this is often problematic, because sometimes taking the help is outing them within the system. Therefore the use of illegal drugs is even more clandestine as outside. It reveals ethical, professional (medical, psychological), cultural, political and technical aspects.

In the prison subculture drug users are often perceived to be at the lower ranks of the hierarchy: they are blamed for new supervisory and control procedures, which aggravate the custodial conditions.

With regard to therapeutic resources the prison health service is in a dilemma: on the one hand the staff of prison health care units and the security staff have to deal with these consequences of drug consumption, while the causes of the diseases usually remain beyond their reach. An adequate response to the health problems of often short-term sentenced drug users is often beyond the capacity of the prison staff and administration - prisons are in no way therapeutic institutions. On the other hand the time of imprisonment should not be a 'lost time'. The opportunities prisons may provide in terms of a medical care and social support should be used: "For prisons can provide an opportunity for intervention with this group, many of whom will not have had any previous contact with helping or treatment agencies" (Turnbull/McSweeney 2000, 41). A prison sentence is a major intervention, which can be utilised for many reasons: to refuel for street life (Timmermans 1998), to start changing social and health behaviour. In many ways people change their drug use patterns they were used to before imprisonment: voluntarily or not. Because of a lack of drugs they might stop their drug consumption at all or reduce the quantity or change the route of administration because of a lack of sterile syringes. In some studies it is reported that while a lot of prisoners were using drugs in a group with friends before imprisonment, while in custody this pattern changed and almost all the prisoners used drugs alone (Nesheva/Lazarov 1999).

Risk reduction strategies, which are applied outside prison, are often regarded as undermining the measures taken inside prison to reduce the supply of drugs. To support on the one hand hygienic use of illegal drugs (e.g. by means of bleach and syringe/needle provision) and confiscate them on the other hand is a fundamental dilemma, which had been perceived by outside professionals 15 years ago, when the AIDS crisis began. Risk reduction strategies are regarded as a challenge to the policy of drug free orientation in penitentiaries, not taking the risks connected with drug use serious enough. These risks are the focus of harm reduction strategies which is an additional strategy to drug free-oriented measures. Drug use itself should be avoided, but when it occurs - and that seems to be the case in most prisons - irreversible damage to the user’s health and to that of other inmates, the personnel and partner, families in the community should be avoided. Inmates should not leave prison with more health damage than he/she had when entering prison. This point of view is clearly supported by the World Health Organisation (WHO).

III.2.2.Heath care organisation

Central issue of the organisation of health care is to guarantee the Health Care Rights of prisoners:

- access to health care (informed, regular and appropriate according to the need, applying the same standards as in the community)
- confidentiality (medical information, interventions on the basis of informed consent, blood borne viruses followed by counselling and treatment).

In all but three examined countries (France, Italy, partly England and Wales) health care matters are laying in the responsibility of the Ministry of Justice. Sometimes there do exist drug strategy units who elaborated specific drug strategies for the whole or part of the country, sometimes only for certain regions. In some countries specific steering groups have been set up to observe and monitor the developments and possibilities of an improvement of health care for prisoners and especially for drug using inmates[27]. These steering groups are either organised as a standing conference or as a group for a single purpose and a certain time frame. In 1999 the Minister for Justice, Equality and Law Reform of Ireland for instance requested the Director General of the Prison Service to establish a Steering Group on Prison Based Drug Treatment Services. The Group consists of senior prison staff, representatives of the Department of Justice, Equality and Law Reform, Prisons Psychology Service, Probation and Welfare Service, Prisons Education Service, the Director of Prisons Medical Services and several nominees of the Eastern Regional Health Authority (Irish Prisons Service 2000). In Sweden the 'National Prison and Probation Administration' has set up a national commission to tackle the problems related to the increasing drug users in prisons.

With respect to the organisation of medical care, medical services are available in all European prisons in one way or the other. Larger penal institutions mostly offer their own medical units, while smaller units work closely together with doctors from the community. Prison hospitals and prison based psychiatric hospitals for 'mentally abnormal criminals' for certain regional areas are models for the majority of countries in which medical care is in the responsibility of the Ministry of Justice.

In most European prisons, doctors may not be chosen freely, which means that the relationship between patient and physician is a coerced contact, which can lead to a different doctor-patient relationship than that outside the walls of a prison. Inmates often have a general tendency to mistrust doctors and meet them with reservation and prejudices.

The relation of General Practitioners (GP) to the inmate population differs. In the Netherlands for instance there is one GP for 300 detainees, 1 nurse for 50 male and 30 female detainees. Most of the 39 detention centres employ psychologists and/or psychiatrist.

The encouragement of health promotion among drug-addicts as well as taking care of HIV patients in this difficult environment depends heavily on the relationship doctor-patient. A recent study on this relationship undertaken at the men unit D1 of the Fleury-Merogis prison in France (D. Khodja, UCSA des Maisons d'arret de Fleury-Merogis, France) highlights issues of trust, medical secrecy and patient choices.

[27] e.g. Denmark the Directorate of Prisons and Probation has appointed a permanent working group whose task is to keep up with the development in the area of alcohol and drugs to consider the principles and possibilities of treatment in relation to users in the institution system of the Directorate.

Also for treatment of HIV-infection and the compliance by inmate patients the best basis for a successful treatment is a close and trusting co-operation between doctor and patient. The better the prisoners are informed about HIV infection, drugs for treating it and their potential side effects, the better tolerated and more successful the treatment will be.

Throughout Europe treatment orders given within different stages of the criminal justice system differ widely and is not subject to this study. There are examples of referring drug users already from the police arrest or remand prison to treatment facilities ('early intervention', Netherlands, Germany in some pilot projects[28]), to be put under probation in order to undergo treatment, or to start a certain form of treatment in order to avoid punishment before court, or drug users can be ordered to follow a treatment and to suspend the sentence until the end of the successful treatment finish. There are moreover several models of community service orders etc. This report will focus solely on treatment of drug users within the prison setting. There may be different motivational aspects relevant, certain incentives are given to initiate treatment (certain form of privileges, i.e. transfer to an open prison) or early release (after serving half or two third of a sentence, e.g. Germany).

In most European countries treatment plans are made for every prisoner for the duration of the prison sentence, that means also for (formerly) drug using prisoners. In Sweden Krantz/Ekström (2000) explain that this plan also covers measures to be taken after release. This is the case in Denmark as well. Treatment plans include steps towards social rehabilitation and health promotion in order to strengthen personal competencies. If necessary, treatment measures are included and progress will be reviewed by staff or special treatment boards. Although through care planning is perceived is seen as inevitable in order to deliver adequate services, this is hardly to achieve for those with a short-term sentence, especially women. In HMP Holloway/London/UK for instance the average stay in prison is 28 days.

Most countries apply a model of mixed professionals in the care of drug users: external experts are integrated for consulting and therapeutic purposes and are to assist internal professionals in charge for care matters. This type of organisational structure enhances the ties between prisons and the community, to assure the continuity of treatment of either drug consumers entering prison or convicts leaving prison (Garzon Otamendi/Silvosa 2000, 89). On the other hand the bonus external professionals from NGO's have in terms of confidence can be used inside by inmates, who often mistrust prison structures, even in care matters.

It seems to be consensus throughout Europe that close co-operation of prison drug treatment services and relevant community services have to be established in order to facilitate dialogue and throughcare for persons treated in prison for drug dependency. This can be characterised as 'holistic' approach. In some drug strategies (i.e. Irish Prisons Service 2000) the need for an establishment of special liaison groups with relevant community interests is felt to be appropriate.

The above mentioned three countries are shortly described because they have been re-organising their health care services in prison and form an exception[29]:

France: By law No. 94-43 from 18th of January 1994 the responsibility has been transferred from the French Ministry of Justice to the Ministry of Health. Every penal institution is closely co-operating with a general or psychiatric hospital team nearby. These hospital teams provide medical and psychiatric care in

[28] more information for the situation in The Netherlands by Amsterdam Institute for Addiction Research, Keizergracht 582, NL-1017 EN Amsterdam

[29] A shift from responsibilities for health care from the Ministry of Justice to Ministry of Health is demanded by several experts (e.g. for Ireland: Dr. Joe Barry 2000 in: Irish Times 9 Nov. 2000)

the prison. It is in the responsibility of the psychiatrist in charge who is providing drug counselling and treatment services. In 16 large short stay prisons there are specialised treatment centres for drug addicts, which are aiming at preparing release and co-ordinate help facilities in the region. In a few recently built prisons, health care for prisoners is sub-contracted to the private sector. In the other 170 prisons external specialist treatment centres are responsible for drug services that supplement the care of the medical teams inside and are responsible to prepare drug dependent prisoners for release (Trabut 2000, 22; see also Favreau-Brettel 1998). In correctional establishments managed by private structures, the latter are responsible for providing the medical service in accordance with the principles and guidelines laid down by the health authorities.

Italy: A new Law[30] has modified radically the situation on assistance to drug users in prisons in Italy: From 1.1.2000 the assistance given to drug users is under the responsibility of local health agencies. Now the SERTs[31] (Addiction Treatment Units - which are part of the National Health Service). This ‚Decreto Legislativo' changed completely the way that assistance to drug users is given in prison.

England and Wales: Although ‚CARATS' (counselling, assessment, referral, advice and through care service; see below) and all the drug strategy is still in the hands of the Prison Services all the rest of the healthcare system is now under the responsibility of the Department of Health. The Prison Service Directorate of Healthcare has been moved to the Department of Health[32]. A rapid development of drug services in prison is going on: beside the promotion of 35 detoxification programmes, the increase in the number of rehabilitation programmes from 16 to 42, and in the number of therapeutic communities from 4 to 6, CARATS (counselling, assessment, referral, advice and through care service) has been introduced in October 1999. This is to be an integrated overall strategy focussing on the needs of the great majority of prisoners.

This strategy is comprehensively linking different services, which in some other European countries fall apart: prisons, community services and probation. CARATS must be available in every penal establishment via local, cluster or area contacts with community agencies working in conjunction with prison and probation staff. “This is a pivotal development for the new strategy because CARATS will provide the foundation of the drug treatment service framework, linking:

- The courts and establishments
- Different departments within an individual establishment
- Different establishments upon transfer of a prisoner; and
- Between the Prison Service and agencies within the community.

CARATS will need to provide a range of easily accessible interventions including:

- Initial assessment upon first reception;
- Health liaison with community on prisoners reception to prison;
- Specialist input into pre-sentence reports, bail applications and assessments for home detention curfews;
- Post detoxification assessment and support;
- Specialist input into sentence planning;
- Counselling aimed at addressing drug problems (on individual and group basis);

[30] It is a temporary law proposed by the government and enforced that needs to be converted into effective law by the Parliament, the problem is that the Parliament could refuse to do it, but in the meantime works as an enforced law.

[31] SERTs normally operate in the community and some of them in prison as well as side activity

[32] The reason why the drug matter is still in the responsibility of the Prison Service is that it wasn't under the Directorate of Healthcare, but the Drug Strategy Unit is under the Directorate of Regimes.

- Support and advice on a range of drug, welfare, social and legal issues;
- Assessment for in-prison rehabilitation programmes
- Assessment for post-prison rehabilitation programmes/drug services;
- Pre-release training;
- Health liaison with community upon prisoners' release;
- Liaison with and referral to community agencies to enable effective resettlement.

Beside the development of CARATS two additional steps of new or intensified drug services have been set up:

- New rehabilitation programmes have been launched, which include relapse prevention, cognitive-behavioural and abstinence based 12-step programmes. "These 'moderate intensity' programmes are most appropriate targeted at prisoners who have a documented history of drug dependency and drug related offending." (Prison Service Drug Strategy). They have the aim to enable the participant to reduce or stop using drugs and to address their offending behaviour.
- Therapeutic Communities (TC) are intensive treatment programmes for prisoners with histories of severe drug dependency and related offending.

In some countries, prison based drug treatment services are to be found in nearly every prison; in some countries these services are concentrated in special prisons (for instance Wien-Favoriten/Austria or Mountjoy Prison/Dublin/Ireland which is going to become the national drug treatment centre with multidisciplinary teams offering methadone maintenance treatment, drug free wings).

The environment within which people (have to) live and work has a major impact on their health and well being. This is a consensus in health promotion. This is also relevant for architectural matters of prisons, which despite all power structures should take account the needs of all persons who live and work in prisons. In the frame of the redevelopment of the Irish Mountjoy Prison 'Architectural Guidelines' had been developed, stressing the factors of openness, green spaces in the complex, natural light, ventilation, optimal size of inmates etc. (see Irish Prisons Services 2000).

III.2.3. The principle of 'equivalence' in international guidelines and recommendations

While the United Nations has stated that persons "deprived of liberty" have all other rights retained, and most countries are signatories to this convention[33], the realities of prison life, and death, are grim. Disease transmission in prison, and the impact on the general community, provides ample reason to consider the public health implications of mass incarceration. A number of studies have identified disparities between services inside and outside of prison, in the fields of diabetes[34], mental health[35] and drug and alcohol treatment. Especially for the group of drug users there do exist a variety of international recommendations, which include the principle of equivalence as a basic supposition for the treatment and care of drug using prisoners (see Table 1 and Appendices). This principle means that prisoners should have access to the same medical and health care services as outside and that the outside professional standards of care and cure should be applied in prisons. Prisoners and all detained persons have the right to the highest attainable standard of physical and mental health. They are not sentenced to a insufficient medical care, but to a loss of freedom. The principle of equivalence of course serves as a

[33] Standard Minimum Rules for the Treatment of Prisoners:http://www.unhchr.ch/html/menu3/b/h_comp34.htm

[34] MacFarlane IA. The development of health-care services for diabetic prisoners. Postgrad Med J 1996; 72: 214-217

[35] Hargreaves D. The transfer of severely mentally ill prisoners from HMP Wakefield: a descriptive study. J Foren Psych 1997; 8: 62-73.

baseline in discussing health care services for drug users in prisons, either for their treatment of their drug use or for the prevention of drug related harm, like infectious diseases.

Treatment of drug users and prevention of Infectious Diseases in Prison - Guidelines/Recommendations of International Committees[36]

"The medical services should be organised in close relationship to the general health administration of the community or nation..." (Rule 22(1) Standard Minimum Rules for the Treatment of Prisoners 1955 (see footnote 8)
"...drug use must be taken as reality, steps should be taken...to prevent the illicit introduction of drugs and injection equipment into prisons, to offer help to drug addicts and to allow, in the last resort, clean, one-way syringes and clean needles to be made available to intravenous drug abusers in prison." (Council of Europe, Recommendation No. R (89) 14, 24th of October 1989)
"The treatment of withdrawal symptoms of abuse of drugs, alcohol or medication in prison should be conducted along the same lines as in the community" Council of Europe, Recommendation No. R (98) 7adopted by the Committee of Ministers on 8th of April 1998
"In countries where bleach is available to injecting drug users in the community, diluted bleach (e.g., sodium hypochlorite solution) or another effective veridical agent, together with specific detailed instructions on cleaning injection equipment, should be made available in prisons housing injecting drug users, or where tattooing or skin-piercing occurs. In countries "...where clean syringes and needles are made available to injecting drug users in the community, considerations should be given to providing clean injecting equipment during detention and on release to prisoners who request this". WHO-Guidelines on HIV Infection And AIDS in Prisons (Geneva, 1993, §24)
„In order to guarantee their (health-care-staff in any prison, H.S.) independence in health-care matters, the Committee for the Prevention of Torture (CPT) considers it important that such personnel should be aligned as closely as possible with the mainstream of health care provision in the community at large..." Committee for the Prevention of Torture (CPT), Third General Report 1993
"...measures to reduce risks should be considered, like making condoms available and even syringes for drug users...against drug use should be fought sensibly and reasonably, but it is useless to close one's eyes to reality" Making standards work. An international handbook on good prison practice (The Hague, 1995, p. 84)
Making sterile injection equipment available in prisons „will be inevitable"... (Expert Committee on AIDS and Prisons in Canada, Sept. 1996)

The Joint United Nations Programme in HIV/AIDS (UNAIDS) clearly states: „With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community. But in reality, few prisons provide adequate HIV/AIDS prevention and care programmes comparable to the outside situation. Neither prisoners nor prison staff are provided adequate information and education concerning how to avoid becoming infected. Nor do prisoners have the access to the means of prevention that are available on the outside. This would include condoms, bleach for disinfecting needles, and needle exchange programmes, where these are available in the community".

The European Council also clearly stated for HIV/AIDS policy that all political actions regarding AIDS should be in alignment with the guidelines of the WHO as well as with the principle of equality along the

[36] Because the use of injectable drugs and the spread of viral infections is a rather recent phenomenon in prisons, the United Nations **Standard Minimum Rules of the Treatment of Prisoners**, do not mention this topic explicitly

recommendation No. R (93) 6 by the European Council (see Appendix (A5): Prisoners should be offered the same medical treatment and psychological care as other members of society.

Although in some countries the principle of equivalence of care and provision for the continuity of care is explicitly formulated in official government papers (for Ireland, Department of Justice 1994, in: Dillon 2000, Irish Prison Service 2000), in practice, however, health care provision equivalent to that available in the community is hardly achieved at least for the group of drug using inmates (for Ireland: Dillon 2000; for the UK: Turnbull 2000, 102). O'Brien/Stevens (1997, i) found in their European study on the 'Implementation of International Guidelines on HIV/AIDS in Prisons of the European Union' that the WHO-guidelines on 'HIV/AIDS in prisons' (1993) are not being uniformly applied in prisons in EU member states. "In general, the principal of equivalence between HIV services in prison and in the community is not applied. In particular, many of the WHO recommendations on HIV/AIDS in prisons are not implemented".

One reason for that is according to Dillon (2000, 38) that different government departments are responsible for the care of drug users in the community than drug users in prison: „This situation creates inherent problems for the continuity of care of drug users. Despite on-going commitments, the principle of equivalence does not prevail within the Irish prison system in its care of drug users." Furthermore some HIV-prevention measures are highly politically loaded, cannot be introduced due to resistance of staff, or are perceived as inadequate for the prison setting (i.e. needle exchange).

In the following chapter it has to be examined to which degree this principle of equivalence is followed in the EU. Drug services in prisons have been developed from 1995 in the European Union although there seem to be big gaps in an adequate provision of treatment, care and prevention offers as Stevens (1998) and Bollini (1997)[37] point out. WHO/UNAIDS (1997) confirm this in a study of 23 prison systems in 20 European countries, representing 387 000 prisoners. It becomes apparent that:

- in most prisons information for prisoner and staff is provided
- condoms are distributed in 18 of 23 systems
- disinfectants are available in 11 systems and methadone treatment in one way or the other only in 9 systems (see for detailed analysis chapter 3.4.).

III.2.4. Medical services and examination

Nearly in all European prisons every inmate is seen by the prison doctor on admission within the first 24 hours for a medical check. Nearly all prisons have a health unit including doctors, nurses and psychologists. Smaller prisons often rely on private contract doctors (i.e. Germany). The dimension of the teams varies according to the prisons and their capacities.

In-treatment Health Units: cases with special health needs are referred to the Prison Hospital. They also may be referred either to the other facilities in the Prison System or the National Health Services.

[37] Bollini 1997 suggests to install demonstration projects to implement the WHO guidelines on HIV/AIDS in prison as example: These pilot projects should be supervised and co-ordinated by UNAIDS or WHO (p.12): „The presence of international organisations would provide symbolic and scientific authority to the program, and would ensure effective dissemination of its results. It is important to stress that harm reduction projects in the participating countries should not necessarily be the same, but should respond to the current needs of each partner. Each project should implement, and duly evaluate, one aspect of WHO Guidelines...."

III.2.5. Training of doctors and staff

Both doctors and prison staff are confronted with drug use in their everyday routine work. Multiple drug use of benzodiazepines and opioids is widespread, withdrawal and craving are phenomenons which occur relatively often. The symptoms are often misunderstood or attributed to the status as drug user as a whole. Van Alem (1999,8) states that although this is a recognised phenomenon, medical doctors and prison personnel have to deal with, little is known 'in fact'.

Therefore it is seen as vital that staff get adequate training at all levels in order to tackle the problems connected with drug use in prisons and to move towards a more treatment focused approach. “In particular, prison officers will need training in intervention skills for drug misuse, including prevention work and perhaps skills training around motivational interviewing, so that they can intervene usefully with offenders” (Irish Prisons Service 2000). In many prisons staff is trained to cope adequately with drug related problems or with behaviour of drug users, whether this is the case for all staff grades including GPs, counsellors, psychiatrists and social worker is not clear. The transmission of information, messages and harm reduction means is intended. In some countries (Portugal) certain modules on 'drug and drug addiction' have been developed. In some prisons multidisciplinary teams are installed and an close exchange of information between prison health services, probation and treatment services which aim to facilitate the treatment out of prison (see CARATS in England/Wales). In many countries new staff receives at least modules on substance awareness in their initial training, but there is also vocational training for staff on a periodical basis on relevant topics or refresher courses. In many prisons the value of positive contribution of each staff member to the drug treatment ethos in the prison system is acknowledged.

Often there is very few training on coping adequately with drug addicted prisoners, although it is said in many prison based publications that all staff with contact to drug using prisoners should have a basic understanding of drug use. Measures available to tackle (Training) it are often control oriented:

- how to take Mandatory Drug Test samples
- how to do cell and body searches.

In this sub-chapter it is described which training programmes are designed at helping staff members handle these situations adequately. Moreover an overview is given of the training programmes offered to prison staff in the EU member states:

- who offers training and which goals are pursued (general information, assessment and interviewing skills of staff, training on counselling); which groups are targeted (general staff, selected staff in residential units?)
- which role does the drug issue play in the training of prison staff?
- what are the competencies in special phases (i.e. entrance unit) and drug use patterns, (i.e. intoxication, withdrawal symptoms etc.)
- development of a specific curriculum?
- integration of outside agencies in the training?
- availability of refresher courses?
- location of the training: inside or outside prison?

Principles of good practices regarding staff training:

1. Prison staff need training and regular updating on all aspect of HIV, Hepatitis and drug abuse - medical, psychological and social - in order to feel secure for themselves and also be able to give prisoners appropriate guidance and support.
2. Prison staff should always be aware of, and apply general protection measures against virus transmission. It is not important to know the sero-status of the prisoners, and all must be equally handled, i.e. as if they were positive, mainly due to the window period, and in order to avoid discrimination.
3. There must be regular opportunities for exchange of information and best practice between prisons and outside agencies at all levels.
4. Prison staff also needs to be vaccinated, at least against Hepatitis B, which is a potential risk for them when searching pockets and bags.
5. Prison staff need exact plans how to handle any situations of emergency.
6. Protocols for HIV/Hepatitis/TB outbreaks should be prepared.
7. In their role as health care providers, prison staff should be fully informed about post-exposure prevention measures, in line with the local policy.

Interventions focusing on drug users

There is a considerable and increasing range of interventions focusing on drug users in prison. A study among 15 European Union Member States concludes that all of them provide some form of treatment activity in their prison system[38]. Some form of drug treatment in prisons is provided in all member states.

1. Provision of drugs information to inmates
2. Provision of drug treatment
3. Other methods to reduce drug use in prisons
    - -Detoxification
    - -Drug counselling
    - -Abstinence-based programs
    - -Self-help groups
    - -Relapse prevention
    - -Methadone prescriptions
    - -Other substitution prescription

III.3. Prevention offers

III.3.1. Prevention of drug use

Developments in several countries have shown that the justice system can play an important role in the education of groups or individuals who are potentially at risk to become infected with HIV or other bloodborne or sexually transmitted diseases. Individuals arrested, detained or incarcerated, in police stations, pre-trial detention centres (PTDC) or penal institutions can be informed, trained and provided

[38] Turnbull/Webster 1998

with the means to protect themselves. Often they are in contact with help facilities for the first time in their life, although being drug users for a fairly long period of time.

The authorities in most countries have provided legal facilities on nearly every level of the criminal justice system in order to check the drug user's ability to undergo treatment. Since the late eighties beginning of the nineties authorities are aware of the problem drug users have and drug users cause in all stages of the criminal justice system. Since then the number of options for counselling and treatment offers increased: "In every step of the judicial process, it should be asked whether treatment could be a viable option either as an alternative to detention or punishment or even during the prison sentence." (van Alem/Wisselelink/Groen 1999, 4; see also as example for Netherlands). Some of these options could be characterised as coercing drug users in treatment by early intervention or while in prison.

Prevention and treatment are carried out partly through the use of various alternatives to custody (e.g. community order), partly through offers of placement in drug-free units and contract treatment units, etc.

Out of different reports the following baselines of prison drug policy can be fixed:

- Keeping distance to drug using subculture. Drug users who are motivated to undergo a treatment programme have to be able to do so in an environment, which allows them to keep distance to the drug scene in prison (protected environment). This is difficult to reach for many prisons due to overcrowding (see Council of Europe 2000).
- screening, counselling and treatment on a voluntary basis
- discouraging drug use import, traffic within the prison system
- offering those diversity of measures which has been applied outside networking of inside social services, drug-care units, probation services and outside social and health workers in specialised drug counselling and treatment services

Information about effects of drugs, harm reduction measures and prevention of acquiring blood borne viruses is in every EU-member state regarded as a prerequisite for behavioural change or at least a change in attitude. Some Member States have consolidated social and medical support towards drug addicted offenders using the first contact with enforcement authorities as a door to treatment or counselling facilities. The entrance situation in prison is often perceived as a setting permitting to contact and discuss future plans and drug free orientation. In countries where the principle 'Therapy instead of Punishment' is reality, chances of an early transfer into therapeutic communities outside can be discussed. It is also the first opportunity to hand out brochures, leaflets or other material which is designed to avoid health damages. For instance in Austria starting in 1998 each prisoner has been given a 'care Pack' at the beginning of imprisonment, containing an information folder, condoms and a leaflet indicating specific risks in order to sensibilize inmates. (Österreichisches Bundesinstitut für Gesundheitswesen 1999, 40; also in the French speaking part of Belgium).

It is of great importance who is carrying out the prevention work, where and with what kind of messages? Todts et al. (1997, 96) showed that an independent team that offers counselling and support was welcomed and trusted by the inmates.

Several modes of interventions have been developed. In Austria a one-year campaign was started in co-operation with the AIDS Assistance Service, in the course of which information days are organised in all prisons. The aim of this initiative is to make the staff aware of the problem and to nominate a prevention representative in every prison, so that prevention strategies for prisoners may be developed in each prison (Österreichisches Bundesinstitut 1999, 40).

Which objectives to be achieved by the help provided to drug users in detention can be formulated despite the above-mentioned hindrances? As has been mentioned before the standards applied in prisons for the help provided to drug- users must be adjusted to the standards applied outside prisons. It seems unrealistic that all inmates with a drug-using experience are expected to change their behaviour drastically in detention, i.e. to live abstinently. Providing help to drug-users in detention is designed to give them an idea of a realistic and alternative lifestyle: "Providing help to drug-users aims to raise and strengthen the inmate's self-motivation and their feeling of responsibility. Changes only occur gradually. These attempts must be supported by providing a variety of aids which help drug-users to become aware of alternatives" (Borkenstein, 1994, p. 80f).

In most European prisons information on the risks of drug use in prison is given to prisoners individually and orally by staff member or social/health services. Additionally mostly in prison written prevention material from the community is handed out to prisoners, only in a few cases material is produced internally for the specific target groups.

In the nineties nearly all prisons in Europe do apply a dual strategy of supply and demand reduction: "Slowly we seem to be reaching the end of the battle over the principles. Today most experts and policy makers agree that it must not be either supply reduction or demand reduction bit that both strategies must get simultaneously equal attention and funding" (Goos 1996).

III.3.1.1. Supply reduction

Drug testing via urine control is a widespread strategy applied in all European prisons both for purposes of medical/therapeutic and/or control. While in medical terms drug testing is indicated in order to check further risk exposures or to see if a certain therapy can be applied, continued or if it is successful or not (i.e. methadone treatment).

In control terms urine testing in many countries is applied in order to check if drugs are used inside prison, if certain measures or privileges can be continued (home leave etc.). Sometimes urine testing is only applied in the context of certain decisions (release, home leave, visitors), in England/Wales a systematic policy of mandatory drug testing has been operating among the inmates of all prisons (a 10 per cent random sample of the total prison population was tested each month). The testing procedure is at follows: a certain proportion of the prison population is tested randomly (10% per month), another part is tested on reasonable suspicion of having used drugs, as part of a frequent test programme, ordered after the prisoner has been found guilty at adjudication of a drug-related offence, as part of the risk assessment process, for example in considering granting temporary release or transfer to a lower security establishment and on first reception or transfer from another establishment (see Prison Service Drug Strategy). The practical effectiveness is under consideration and this policy might be revised in the near future. This is done on a mandatory basis to monitor the spread of drug use in prison (England and Wales). Mandatory Drug Testing (MDT) was introduced in all penal establishments in England and Wales between September 1995 and March 1996. MDT aims to deter prisoners from misusing drugs through the threat of being caught and punished, to supply better information of drug misuse, to improve the targeting of treatment services and to identify individuals in need of treatment. The results are a reduction of positive random mandatory drug tests positives from 25,3% in 1996/7 to 20,7 % in the first quarter of 1997/8 to 14,5% at the end of the financial year up to the end of February 2000 (Cannabis 10.5%, Opiates 4.4%, benzodiazepines 1.1%, Cocaine 0.2% and Amphetamines 0.1%).

This policy has been criticised for different reasons (i.e. for encouraging drug users to switch from drugs with long urinary half-lives (i.e. cannabis is detectable for up to 30 days in contrast to heroin which can be detected for up to seven days) to those with shorter half-lives (i.e. heroin; Gore et al, 1996). “Data from the MDT database shows no upward trend in opiate positives, to match any downward trend in cannabis positives and neither research study found evidence to suggest that switching was a problem. “Nevertheless the Prison Service cannot afford to ignore the possibility that switching is taking place. There would be serious health implications if significant numbers of prisoners did switch from cannabis to opiate use.

Part of the future research programme ... will therefore be to conduct a thorough investigation of mandatory drug testing.” (Prison Service Drug Strategy). According to a accompanying study 4% of the drug users had experimented with heroin for the first time because of MDT, but none had persisted with it.

But also from a different perspective MDT’s are critiqued: The Chief Inspector of Prisons Sir David Ramsbotham condemned the system as useless. He argues that MDT’s showing that one in five inmates is using drugs failed to demonstrate the scale of the problem and all prisoners should be tested the moment they arrive in prison. Moreover he argues that prison officers should be subjected to random drug tests, which he claimed would help to ally suspicion that some supplied inmates. He favours ‘dip tests’ which involves a urine sample being assessed more cheaply with piece of litmus paper costing only few pence. The sample is only sent off for full analysis if it is suspicious (Telegraph 30/6/1999.

There are several activities in prison aimed at reducing the supply of drugs in order to reduce or prevent the use of drugs in general. Reducing the supply is a difficult task and a ridge walk: “Drugs are relatively easy to hide; drug dealing is a potentially curative activity; and isolating all prisoners from any contact with the outside world would compromise a great deal of work on maintaining family ties and facilitating resettlement. Prisoners also demonstrate considerable ingenuity in trying to find ways to circumvent security procedures”. (Prison Service Drug Strategy England and Wales). Despite of all activities it seems not realistic to eliminate drugs from prison, but only to reduce the amount smuggled in. Several searching procedures in order to control the drug use (either illegal drugs, medication or alcohol) situation in prisons can be listed up:

a) Urine analysis (various drug testing procedures)
b) cell searches
c) body searches
d) drug checks in prison visiting facilities

a) Urine analysis (various drug testing procedures)
In nearly all prisons drugs are detected via urine analyses (seldom hair analyses) at various stages of custody and in various forms.

- routinely, for example daily on drug free wings, drug free units
- before entering treatment programmes
- randomly
- before granting leave from the prison so that only 'clean' prisoners can expect to have leave
- on return from leave
- on suspicion of individual or collective use of drugs (see also Ekström et al. 1999, 13)

b) cell searches
Prisons often do have certain protocols and rules in which intervals cells are searched. In some German ‘Länder’ every cell has to be searched at least once a month.
c) body searches

Body searches do occur on suspicion and more routinely after home leave or holiday.
d) drug checks in prison visiting facilities
Since 1997 the French police have been encouraged to perform checks for drugs in prison visiting facilities under the authority of the public prosecution service. As in several other countries it is more of a symbolic and deterrent effect because the quantities found are very small. (Trabut 2000). Nevertheless is it is suspected that visits of friends and family members is the most common route for smuggling drugs into prison (Advisory Council 1996). In England and Wales supervised controls of domestic visits resulted in 1174 visitors being arrested in 1997 on suspicion of smuggling contraband. Many penal institutions therefore have developed different restrictive visit procedures. This of course negatively affects all non-drug using prisoners and visitors.

III.3.1.2. Demand reduction

Reduction of demand primarily means prevention, however not primary prevention because most members of the target group, prison inmates, are already in contact with drugs. The goal to be achieved is rehabilitation, which should lead to a drug-free life resp. to an awareness of risks associated with the use of drugs especially in the prison setting.

For this reason most support projects offered are designed to induce addicts to live abstinently. It is doubtful if the objective to make inmates start a drug-free life during detention and to keep it up, is realistic, all the more so because drugs are relatively freely available in detention and the inmate's past which was often dominated by drugs cannot simply be wiped out. In many cases the implications of a criminal lifestyle become apparent in detention: blackmailing, debts to become extremely dependent on other inmates and violence.

In view of the increase in drug consumption in prisons it is imperative to provide adequate helping services, which meet the needs of those affected. The measures taken must be balanced with the requirements for security and good order. The goals pursued should also be pragmatic, not only with respect to the prison system but also with respect to the inmates: harm-reduction should be the guiding philosophy behind the measures. The spatial and methodical range of action for implementing remedial measures in prisons is very limited.

Measures designed to achieve an abstention from drug use in prison or at least a reduction of harmful drug using patterns:

- counselling on drug-related issues (provided by prison staff or specialised personnel, integration of external drug services)
- housing of drug using prisoners in specialised units with a treatment approach and multidisciplinary staff
- organisation, methods applied and goals pursued in drug free units;
- provision of print media and audio-visual material (in different languages, involvement of external counselling agencies in the production of this material?)

Measures to prevent the transmission of infectious diseases among drug users:

- face-to-face communication (counselling, personal assistance, assistance from and integration of outside AIDS-help agencies; 'safer use-training' for drug-users)
- technical prevention

- provision of leaflets
- vaccination programmes against Hepatitis A+B and TB
- availability of condoms
- availability of contaminates (access, with relevant instructions)
- availability of sterile injection equipment and additional material (alcohol swabs etc.)

In most of the examined countries prisons undertake primary prevention actions (i.e. Portugal 39 of 53 prisons[39]), these include information sessions often in co-operation with external experts of the health system or NGO's either in the admission phase or as a continued programme.

As has been mentioned before the standards applied in prisons for the help provided to drug- users must be adjusted to the standards applied outside prisons. It seems unrealistic that drug-using inmates are expected to change their behaviour drastically and sustainable in detention, e.g. to live abstinently. Providing help to drug-users in detention is designed to give them an idea of a realistic and alternative lifestyle: "Providing help to drug-users aims to raise and strengthen the inmate's self-motivation and their feeling of responsibility. Changes only occur gradually. These attempts must be supported by providing a variety of aids which help drug-users to become aware of alternatives" (Borkenstein, 1994, p. 80f).

III.3.2. Prevention of sexual transmission

Sexual activities occur inside prisons, as they do outside, as a consequence of sexual orientation. In addition, prison life produces conditions that encourage the establishment of (wo)men having sex with (wo)men or homosexual relationships within the institution. The prevalence of sexual activity in prison is based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification, and the extent to which conjugal visits are permitted.

Several studies have provided evidence that significant rates of risky sexual behaviour occur in correctional settings. A study conducted among 373 male prisoners at all of South Australia's prisons[40] concluded that 12 % engaged in anal intercourse at least once. An other study in South Australia[41], reported that prison officers and prisoners estimated that between 14 % and 34 % of prisoners engaged in 'occasional anal intercourse'. Research conducted in New South Wales[42] in which interviews were conducted with a random sample of 158 prisoners (142 males and 16 females), seven per cent of the men reported having had voluntary adult homosexual experiences in prison.

The European Network on HIV/AIDS and Hepatitis Prevention in Prison found in their studies rates for sexual intercourse among men in prison between 0.4% (Sweden), 1,4% (Austria) and 5% (Spain), a condom for the last intercourse used between 0% (Belgium) and 30% (Spain; Rotily et. al. 1999). In the Austrian contribution to that Network study (Spirig et al. 1999) found in their inquiry that 2,8% of the men stated that they were raped in prison, only 1,4% stated that they had sexual intercourse with another man in prison, no one stated to accept payment for sexual intercourse, no one stated to use a condom (see below).

Despite the relatively availability of condoms in prisons only poor knowledge of sexual risk behaviour and individual risk prevention does exist. Todts et al. (1997) report that none of those Belgian prisoners

[39] Informar/Sensibilizar/Prevenir' (To inform/To touch/To prevent). Goal is health promoting goal: training of social skills , motivation to healthy activities including sports

[40] Gaughwin *et al., 1991*

[41] Douglas *et al.,* 1989

[42] Potter & Conolly, 1990

having sexual contacts while in prison used condoms. Prevention offers have not been utilised. The reason might be that homosexuality is not really accepted by most of the prison population and prisons do not offer enough privacy for the occurrence of this behaviour.

III.3.2.1. Provision of condoms

The WHO guidelines on HIV infection and AIDS in prisons (1993) recommends: "...Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release.."

The availability of condoms in European prisons is different in practice regarding the provision of and access to condoms. Perkins (1998) examined the accessibility of condoms in European prisons and found a wide range of different policies "...on a continuum spanning endorsement of free distribution within prison to total prohibition. Nine of the fifteen EU countries had clear official policies allowing free access to condoms for prisoners, in line with the WHO Guidelines. The other six occupied different positions on the road towards allowing such access, from the extreme of prohibition based on lack of recognition of the problem." (Perkins 1998, 33[43]).

In Scotland, Italy and Ireland, sexual relations are prohibited in prison and consequently, condoms as well as lubricants are not available for prisoners. They are partly handed out for home leavers and/or as part of the release pack.

In England and Wales, prisoners can get condoms on prescription if the prison doctor believes that there is a risk of STD transmission. The British Medical Association has done a report in "Prescribing Condoms in Prisons". They sent out questionnaires to 126 establishments and 76 replied. Of those nearly one quarter (24%) admitted that they had not taken any steps to ensure that prisoners who may be at risk of HIV were aware that condoms could be prescribed. "Even more, 28%, did not monitor the prescribing of condoms" (McKerrow, 1997, 24)

Throughout the world condom availability is a big issue due to the second taboo in prison (besides drug use): sexuality. In 1995 in Australia, 50 prisoners launched a legal action against the state of New South Wales (NSW) for non-provision of condoms, arguing that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded." Since then, at least in part because of the legal action, the NSW government has decided to make condoms available. Other Australian systems have also made condoms available. Only in the United States does only a small minority of prison systems make condoms available.

The fieldwork indicated the importance of a clear and committing policy. "Implementation begins with clear messages from the top about policy commitment. The message needs to be reiterated through various levels of organisation." (Perkins 1998, 34). One example is the Austrian policy on that matter: In July 1994 the Ministry of Justice of Austria issued the following ruling that "...condoms have to be provided in such a way that unobserved taking out of a container is ensured." (Bundesministerium für Gesundheit 1994, 2). Every prison should plan the installation of such container itself due to the circumstances inside the prison building. Best experiences have been made with sites places like toilet-rooms, waiting rooms, workshops, or day rooms).

[43] see also Laporte 1997 who found in his European survey that in four prison systems (with a total number of of 263 prisons and about 68 000 inmates in 1996) there still was no availability of condoms at all.

Table 6: **Provision of Condoms in some EU countries**

Country	Provision of condoms	Access	Remarks
Austria			Available in 20 out of 29, in 3 only on 'demand', in 4 not at all, in one 'in preparation'
Belgium			Varies widely depending on local prison policy
Denmark		Freely available in all prisons since 1987. Can be obtained from the prison staff and medical service. Placed in visiting rooms.	
Finland		At intake (entering and leaving), by medical unit, in conjugal rooms, freely available without asking	
France		Medical service	
Germany		Medical service, Merchandiser, Social Worker/ Psychologists	In some prisons it is difficult to purchase a prsion when needed: it has to be ordered 7-14 days in advance from the merchandiser.
Luxembourg		condoms and lubricants available in the medical department, prisoners have not to ask for it, they can just take it out of a container	
The Netherlands		Every local governor makes his own policy on the practical form of availability	Due to guidelines, condoms must be available in every prison
Portugal	**40 from 53**	medical office, nursery, educational body	according to the criteria of the prison administrators
Spain		at entry, after that in all cells were prisoners meet visitors, also on demand at medical service	
Sweden		available in cells were prisoners meet visitors	
Few Prisons:	**Most Prisons:**	**All Prisons:**	**No Prisons:**

Reyes (2000) argues that sexual transmission of HIV in prisons is a complex phenomenon, with taboos for all concerned: prison authorities, health personnel, and prisoners as well. Penetrative sex between male prisoners can take place in a whole range of situations, and not just between 'gay' inmates:

- Men having sex with men
- True homosexual sex
- Consensual sex
- Circumstantial sex (prisoners pay with what they have)
- Coercive sex
- Rape and gang rape
- Male prostitution

There are many misrepresentations about the nature of sexual coercion inside prisons, and widespread lack of awareness of the problem. Making condoms accessible to inmates may be useful for some cases, but will certainly not prevent sexual transmission of HIV in most cases of so-called "consensual" prison sex. According to Reyes condoms, education and control are necessary if HIV prevention in prisons is to work.

III.4. Abstinence oriented treatment

There are many arguments against the systematic use of imprisonment for those who are involved in crime and drug use. Prison generally does not have a rehabilitative effect on those it contains. There are harmful consequences of drug use in prisons and learning to be drug-free in prison does little to prepare drug-using offenders for being drug-free on their return to the community. Prisons may exacerbate harms caused by drug use, these harm may then be translated to the community outside of prisons[44].

Abstinence oriented treatment for prisoners is provided predominantly in prison in special facilities (drug free wings, therapeutic communities) - it is the dominant approach of existing interventions. Some countries show an increase of drug free areas since the mid-nineties of 300 and 400% (Austria, England and Scotland; Turnbull 2000, 48). The access to these programmes is voluntary under certain conditions sometimes even with certain contracts for behavioural change. The central objective is being abstinent; therefore urine testing plays a major role to ensure the drug free status. These programmes are mostly run in separate sections of the prison with no direct contact to other inmates and a high control standard. The concept of twelve steps or Minnesota is most common. Drug free wings have been developed especially in Austrian, Dutch, Finnish and Swedish prisons.

According to Turnbull (2000, 47f) 80% of all Council of Europe countries have abstinence-based programmes. Turnbull states that "one of the main reasons why this approach has been adopted within prisons is the perception that prison culture often works against other types of treatment and education programmes." Another reason is that abstinence is identical with the aim of custody in general to enable prisoners to lead a life without committing criminal offences after release. The use of illegal drugs is a criminal offence per se and therefore should be eradicated already inside prison.

Overall surveys for England and Wales indicate that half of the women and a third of the men who were identified as drug dependent in the year before entering prison received help for their drug problem during the time of imprisonment. Also, a substantial proportion had some contact with help agencies during their

[44] Turnbull/Webster 1998

prison stay. Those with opiate dependence were more likely to receive help in the community and were also more likely to receive help in prison, but dependent stimulant users also reported significant levels of access to help within the prison setting.

In most countries a differentiated system of sanctions and incentives have been developed in prisons in order to punish drug using behaviour or to award staying drug abstinent within a unit or a treatment programme. These measures are designed as deterrence for prisoners in the frame in which treatment efforts are organised. Sanctions can be:

- additional days of imprisonment for positive urine tests[45]
- forfeitures of privileges
- stoppage of earnings,
- no home leaves
- no visits

Incentives are designed to encourage good behaviour of prisoners:

- transfer to a drug free wing,
- single cell
- home leave,
- holiday
- in-cell television etc.

III.4.1. Detoxification

As Turnbull/Webster (1998, 181) pointed out, detoxification facilities although varying in length and form are offered in nearly all EU-member states. Detoxification policies vary from country to country and also inside the countries, from state to state, especially in those with a federal structure and responsibility of Justice matters.

In many clinic settings in Germany for instance withdrawal of opiates or partial withdrawal in case of multiple addiction are increasingly treated by means of medication. "Cold turkey" (immediate reduction of the dosage to zero) is considered a deterrent because it aims at total renunciation of opiate consumption, it has been replaced with a more pragmatic approach: addicts are treated with medication, which permits an intense analysis of the psychosocial causes and circumstances of addiction. In several clinics the dosage is gradually reduced; withdrawal orients by the patient's requirements, abilities and resources to overcome or at least cope with their drug problem. The treatments also include ear acupuncture or the application of methods of experiential pedagogic, etc. Furthermore in-patient treatment during withdrawal are replaced with out-patient treatments with or without medication.

The procedures in detoxification programmes vary considerably: In Ireland for instance two forms of detoxification are offered: a 14 day detoxification programme, or an intensive detoxification programme which last thirteen weeks. This involves a support group and counselling. After this programme, prisoners are either transferred to the Training Unit (drug free semi open institution) or granted temporary release (Irish Prisons Service 2000). In England 'Post Detox Centres' have been installed, for instance in Holloway. This is a community in which residents and staff work together to create supportive and

[45] The additional days given as punishment for drug offences in England and Wales in 1997 amounted to an extra 360 prisoners places per year (Prison Service Drug Strategy)

confidential environment where inmates can explore drug and alcohol related problems during their time of incarceration. It aims to help inmates become drug free and cope with staying drug free both in prison and on their release. The inmates may stay at the centre for up to three weeks. Topics of group work are:

- Drug and alcohol awareness
- Harm minimisation
- Sexual health
- Dance movement
- Art therapy
- Acupuncture
- Peer Support Groups
- CARAT Assessment
- Access to Free Flow
- Sleep and Relaxation
- Stress Management
- Social Skills
- Goal Setting
- Communication and Relationship Skills (cf. CARAT Team of Cranstoun Drug Services at HMP Holloway).

In the new Prison Service Order (PSO) for English and Welsh prisons (issued 20/12/2000) clear guidelines in line with the Department of Health guidelines (1999) have been elaborated in order to provide effective evidence based detoxification management for all inmates who misuse opiates. One of the central topics is that each prison will have a detoxification service for opiate misusers, developed in conjunction with local National Health Service consultant using evidence-based guidelines in line with the ones developed outside.

As an example for good practice the 'Mandatory Task List' of the PSO will be presented in the following:

- **Assessment**, including signs, symptoms of drug misuse evidence of opiate withdrawal and indications for a mental health assessment
- **Corroboration of information** from GP, local substance misuse service or dispensing pharmacist
- Urine testing
- **Result of urine test to be placed in IMR**
- **The importance of prisoners understanding the need to provide correct information** and the potentially life threatening risk of concurrent illicit drug use during detoxification
- **Detoxification guidelines** for one or all of the following
  - Methadone
  - Lefexidine
  - Dihydrocodeine
- **Observation by trained and experienced staff**, especially in the first 72 hours of treatment, recorded on documentation kept with prescription chart/IMR to permit the recording of regular observations
- If it is not possible for detoxification to be undertaken exclusively in HCC, a protocol for sharing information, having obtained prisoners informed consent, with wing staff must be in place
- Staff training
- **Availability and guidelines for use of Naloxone** in the event of the opiate overdose
- **Requirements for transfer to hospital** in the event of overdose

- Guidelines for the management of those not manifesting withdrawal symptoms
- Referral to CARATs.

Contrary to these new therapeutic standards addicts in many European prisons are still exposed to "cold turkey" upon incarceration, either deliberately, i.e. the prisoners have to cope with the symptoms of withdrawal on their own (not least in order to punish them) or they are not treated in time or not at all. Sometimes the problem is not recognised at all. Frequently prisoners have good reasons for concealing their opiate addiction for fear of restrictive measures or stigmatisation. There are also cases, in which staff of the health care units gives tranquillisers to inmates, which do not have any effect on most of the withdrawal symptoms. While withdrawal from methadone outside prisons is done gradually, the dosages given inside prisons are often reduced rapidly. Only in a small number of prisons methadone treatments are implemented properly so that the considerable physical and psychological withdrawal symptoms are really reduced. A specialist withdrawal treatment that is based on medication also permits detection and handling of side effects and potential sources of infection (cf. Kommission 1995).

Training programmes in which the staff of prison health care units participate at regular intervals should provide the necessary knowledge on the latest standards in withdrawal treatments of opiate addiction or in case of multiple addiction, detoxification treatments of alcohol, benzodiazepine and barbiturate addiction. It is advisable to seek the advice of outside doctors, which are specialised in medication-based withdrawal treatments.

Counselling and support services for inmates participating in withdrawal treatments in prison cannot be effective without the aid of outside drug service providers. It has become apparent that the staff in many health care units of prisons works unsystematically, has no clear idea about the course of the treatment and does not document the data properly: This applies to examinations at the beginning and end of infectious diseases as well as to examinations of other typical side effects of opiate consumption as for instance tuberculosis.

III.4.2. Drug free units and drug free wings[46]

Drug free wings or contract treatment units aim to allow the prisoner to keep distance from the prison specific drug scene and market and to provide a space to work on addiction related problems. Non drug using prisoners should be protected from drug using inmates and drug free units aim at better identifying drug addicted inmates and better control of them. The focus in these units is put on 'drug free living' mostly combined with community living in order to utilise positive group atmosphere and the effects of 'peer group education'. The prisoner stays in these units on a voluntary basis. They commit themselves (sometimes with a contract) to abstinence from drugs and not to bring in any drugs and they agree to regular medical check-ups often associated with drug testing. On the other hand, prisoners staying in these units enjoy a regime with more favours, like additional leave, education or work outside, excursions, more frequent contact with the family etc.

As a differentiation to ‘drug free units’ the term ‘drug free wings’ (and synonymously used ‘drug free zone’ i.e. in Austria in ‘Hirtenberg’) usually doesn’t necessarily include a treatment offer. These wings aim to offer a drug free environment for all those who which to stay on distance to drug using inmates. Depending on the concept a model with gradually given privileges and promotion of autonomy is developed in these wings (Haas 2000).

[46] Drug free wings, drug free units are used synonymously

Drug free units have been developed since the beginning of the nineties, in some countries since the late nineties. In several countries the number of places is rapidly increasing (e.g. Austria ÖSTERREICHISCHES BUNDESINSTITUT FÜR GESUNDHEITSWESEN 1999, 40). Despite this development there is only little scientific evaluation work carried out.

In **Portugal** drug free units cover almost half of the whole in treatment facilities provided to prisoners in Portugal (304 beds out of 741). Moreover in other prisons (juvenile and women prisons) health care facilities for drug using inmates are provided. These drug free units include a variety of treatment offers like TC units, methadone maintenance, and motivation to treatment, drop in and drop out. The main policy is to provide drug addicts similar conditions as those outside the prison. In France there does exist a pilot project since 1998, where during 3 months inmates voluntarily work on their addiction problems (alcohol, pills and illegal drugs). In Denmark according to Reventlow (2000) it is distinguished between contract treatment and drug free units:

Contract treatment units and drug-free units

The purpose of the stay in a contract treatment unit is that the inmate will remain drug-free, or at least motivated for continued treatment after the imprisonment. In this connection, attempts will be made to motivate the inmate to strengthen his or her health and personality, to participate in the ordinary work routines and to maintain and strengthen his or her social network.

Prior to placement in the unit, inmates have to declare, by signing a contract, that they are willing to remain drug-free during their stay, to submit to regular urine sampling to check the absence of drugs and to participate actively and positively in the life of the unit. The unit at the same time undertakes to create a positive framework for the term in prison.

The unit offers the drug addict support in the form of close staff contact and possibly relaxed prison conditions for treatment reasons against the inmate refraining from taking drugs during his or her prison term. The contract treatment units work with group therapy and behavioural consciousness. The treatment principles for the contract treatment units reflect a fundamental concept that it is possible to support the inmate in his or her decision to stop the abuse by close personal contact and talks with abuse experts. Thus, a person is attached to each inmate in a so-called contact person scheme in the units. The contact person is responsible for the inmate's treatment plan and for handling casework in general concerning the inmate. Moreover, treatment consists in sessions with supervisors, who are external persons having a theoretical and practical background as therapists. Regular sessions - tripartite talks - are held between the contact person, the supervisor and the inmate to uncover the inmate's development and the course of the future treatment.

Another part of the talk-based treatment of the inmates is the so-called group dynamics. This consists in motivation of the inmates also to support each other internally in the everyday life in the unit. Group dynamics are developed by creating good physical surroundings and an open environment in the units and by participation of both staff and inmates in a series of activities in and outside the unit. One of the contract treatment units holds regular meetings with Narcotics Anonymous. The work on behavioural consciousness uses elements in the Cognitive Skills Program as its point of departure. Finally, the units work with the concept of the consequential teaching procedure, which means that an inmate caught using drugs or counteracting the principles of the units is expelled from the unit.

The treatment strategy for the contract treatment units contains an individual element, as treatment plans for all inmates take into account the treatment needs of the individual. The treatment plan sets out targets for the inmate's stay in the unit, and a decision is made on any further treatment outside

Example for a close co-operation of community service and in-prison treatment: the Kongens 0 pilot project in Denmark

In September 1997 as a three-year pilot project the closed State Prison of Vridsleselille opened a contract treatment unit for drug addicts capable of accommodating 15 inmates. A private (non-profit) treatment institution is in charge of the contents and implementation of the treatment, but the unit officers, the after care employees the nurse etc. co-operate closely with the therapists from the treatment institution and thus participate in the treatment of the inmates.

The pilot project was set up upon recommendation from a working group consisting of representatives from the prison. The Department of Prisons and Probation, the Minister of Social Affairs, the treatment institution and the counties, but the actual idea was originally conceived in the prison itself. Because of the very positive professional experiences with the project it has been decided already half way through the pilot period to expand the project by a further unit with 15 places, which means that the capacity is now 30 treatment places.

This project should be viewed as part of a train of initiatives offered to drug addicted heavy criminals. The first two steps were taking according to the strategy followed until then, which was that, in principal, offenders serving a sentence must have access to treatment at the same places and level as other citizens. Setting up parallel treatment offers especially for inmates, was not considered an unconditional advantage to the inmates involved, as it was thought that range of offers that would be possible in reality would be smaller than for other drug addicts in society.

The result was that criminal drug addicts only received an offer of treatment outside the prison, when the risk that they would abuse the required leaves was asset as small.

The Kongens 0 project is a fundamental break with the former strategy and the most unconventional step so far taken by the prison and probational service. Behind the initiative lies recognition of the fact that this particular type of group is often in reality cut of from using the ordinary treatment offers of society.

The target group for the treatment are inmates who are drug addicts and who themselves want to become non-addicts and who also, after being made acquainted with the contents of the treatment, sincerely wish to participate in the programme. The inmates come from both the Vridsloselille State Prison and from the other state and local prisons of the Prison and Probation Service.

In connection with referral of inmates to the unit, there are in principle no restrictions concerning the length of the inmate's residual sentence, but the length of the residual sentence may, however, become important to the possibility of participation upon specific assessment. It is assumed, though, that the primary target group of the project are inmates who can be released for continued treatment outside the prison after completion of their treatment in the unit.

The stay in a treatment unit averages about 4 months. In some cases, the stay may be somewhat longer.

The residual sentence must be about 3 months as a minimum for the inmate to have time to benefit from the treatment. Experience shows that the stay in the units will typically extend to about 1 year at the most. This is because the stay is of such an intensive nature that it becomes too tiring to stay in such an environment for a lengthy period.

The conditions for staying in a treatment unit differ greatly from what inmates are used to in an ordinary Danish prison unit.

By signing a contract, the inmates declare their willingness to observe the special conditions for their stay.

A significant difference is that the inmates are completely cut off from association with inmates in the remaining part of the prison during all 24 hours of the day. In some areas, the conditions interfere more in the individual's private life - if there is a therapeutic reason for it.

This applies to the possibilities of visits and leave, for example. In other areas more freedom is possible, for example in the form of more cultural outings, possible participation in frequent meetings of Narcotics Anonymous outside the prison as well as family days.

The inmates[9] cells are furnished more or less identically, and therefore, in principle, the inmates cannot have their own things with them, like they normally can in ordinary units. Cleanliness and orderliness are very much in focus. The cleaning of cells and communal areas are part of the daily chores. It is an important part of the treatment that the inmates are trained in self-discipline and personal appearance.

The physical facilities of the unit are extremely well kept, and the atmosphere is pleasant and friendly. The prison look has been kept down by giving the unit nicely matching colours on walls, curtains, bed covers, etc. Repairing and refurnishing the unit are part of the inmates' employment.

Another essential part of the treatment is a healthy and varied daily diet for the inmates. Therefore a catering officer is employed to be in charge of catering. This differs from the ordinary prison regime, as in practically all Danish prisons so-called self-catering was introduced during the 1980s based on the philosophy that the day-to-day lives of the inmates should correspond as much as possible to life outside the prison.

An extremely positive culture has been established in the units, where inmates, staff and the therapists from Kongens 0 collaborate closely on freeing the inmates from their drug addiction. At the same time, it has been possible to maintain the necessary professional distance between, on one side, prison staff and the therapists and, on the other side, the inmates.

The scepticism towards the therapists that could be traced among staff at the beginning is no longer present.

The permanent staff connected to the unit show great commitment and initiative. No doubt, the new approach to the inmates that the staff has gained through the treatment collaboration has resulted in increased job satisfaction among staff.

The treatment is based on the Minnesota model and its 12-step programme.
The therapists from Kongens 0 are former drug addicts .The everyday life in the treatment units

passes basically according to the following "treatment schedule":

On all workdays there is a morning meeting based on a specially selected text. The morning is then spent in intensive group therapy, which typically reveals very private and intimate details about the individual and his problems. In the afternoon, the therapists typically give lectures on a relevant subject related to drug abuse. In the evening, the inmates have their own "evening meeting" without therapists present. Furthermore, during the week the inmates have leave to go to NA meetings, and about twice a week they participate in various sports activities.

It is a condition that a detailed action plan is drawn up when the individual inmate is referred to the unit, and this plan is followed up as the treatment progresses. If it is foreseeable that treatment must be continued after release, the prison should contact the inmate's county as soon as possible to ensure co-ordination about the action plan concerning both the service of the sentence and post release initiatives in order to establish the necessary coherence and overview of the entire further treatment programme.

Since the beginning of the project, there have been no instances of drug abuse in the treatment units. This is mainly checked through frequent tests of urine samples.

There are continuously a large number of leaves from the units. So far, these leaves have caused no problems of abuse or smuggling of drugs. There have only been two individual episodes of abuse outside the unit - one in connection with hospitalisation, the other during a stay in the prison sick unit.

Drug-free units are placed in an open and a closed prison, where inmates who are motivated to serve their sentence without being tempted to take drugs.

Table 6: **Places in drug free units in some EU countries**

Country	Places	Source
Austria	700	
Belgium	16 (specific programme in one prison in the Flemish part)	De Maere 2001
Denmark	1 unit in a closed state prison (16 male) 1 unit in an open state prison(22 male/female)	Reventlow 2000
France	no drug free units	Khodja 2001
Ireland	170 (1 Semi Open Institution (Training Unit 96 spaces), 1 Drug free wing in Juvenile closed Institution (St. Patrick's – 74 spaces)	
The Netherlands	476 (3.6% of total cell capacity)	van Alem et al. 1999
Portugal	304 beds (in a total of 741 beds from the in treatment health units of the whole system)	Machado Rodrigues 2000
Spain	in 1999 6456 inmates have been included in drug free programmes in 14 prisons (including therapeutic drug free orientated measures and day clinic); 1.299 inmates received naltrexone antagonist as support	Ballesteros 12/12/2000
Sweden	346	1.10.2000 Krantz/Ekström 2000

Bieleman et al 1999 (quoted in van Alem 1999, 10) found in a small sample in asking drug users about their experiences during their stay in a drug free unit that they reported that the program was too much aimed at drug free living and psychological counselling instead practical help for daily problems and in preparation of discharge (finance, work, housing).

Drug free unit should be one phase in a treatment strategy in prison. Often trained personnel are lacking.

III.4.3. Therapeutic Communities in prison

Therapeutic Communities (TC) are intensive treatment programmes for prisoners with histories of severe drug dependency and related offending who have a minimum of 12-15 months of their sentence left to serve." The TC methodology provides a distinctive approach of the treatment of substance misuse as well as other dysfunctional behaviours that often accompany the misuse of drugs and alcohol.

TCs are 'drug free environments' which operate a total immersion view of treatment that requires 24-hour residential care and comprehensive rehabilitation services. Residents are expected to take between 6-12 months to complete the programme." (Prison Service Drug Strategy). The English and Welsh TCs provide a programme based on a generic model developed especially for the Prison Service by Phoenix House (US).

III.5. Substitution Treatment

Methadone treatment attracts and retains more intravenous drug users than any other form of treatment. In prison it turned out to be successful in reducing the frequency of injecting among inmates and significantly reduced the incidence of hepatitis C (Dolan et al. 1999). This chapter goes into details and gives answers to the following questions:

- How is the situation of methadone prescription in European prisons?
- Are substitution programmes started while in prison and/or are they only prolonged from outside?
- In which form is methadone and other substitutes prescribed: detoxification, maintenance programme (short/long-term prisoner), or as relapse prevention measure (starting with prescription at certain period of time before release)?
- Which goal is pursued with substitution treatment: addiction treatment, prevention of infectious diseases?
- What is the scope and procedure of methadone programmes
- Has an official prescription/detoxification policy or guidelines been formulated on a national or local level?
- How is the availability of additional psycho-social support?
- Is there any involvement of outside agencies?
- How are the links of substitution treatments to other forms of treatment in prison as well as to treatments available in the community after release or on home leave?

The WHO recommends: "prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries where methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons..."

By starting methadone treatment in detention it is hoped that the treatment will help to:

- reduce the demand ('craving') for opiates in detention,
- reduce risks of transmission of infectious diseases (HIV/AIDS, Hepatitis B+C)
- providing grounds for medical contacts and further treatment of diseases
- reduce the number of crimes in prison,
- to stabilise drug-users physically and socially in order to increase their motivation for participation in further support programmes
- providing grounds for participation in working, qualification, training

In order to meet the requirements that drug-addicts in prison should have access to the same treatments offered outside prison, inmates falling into the following groups should be permitted to participate in methadone treatments in detention:

- those who had already started a methadone treatment prior to imprisonment;
- those who apply for participation in a methadone treatment after incarceration, while in prison and who meet the requirements for this treatment.

Substitution has become a widely acknowledged and adopted treatment option for drug users in the last 20 years. It is said that currently 300.000 drug addicted participate in these programmes in Europe. Methadone substitution treatments have a long and varied history across the continent where changes in ethical and political views, medical opinion and legislation have led to developments and changes in prescribing practices. In Western Europe, introduction of the first methadone programmes varied from the late sixties in Sweden, the UK, the Netherlands and Denmark to the seventies in Finland, Portugal, Italy and Luxembourg to the eighties in Austria and Spain and to the nineties in Ireland, Germany, Greece, Belgium and France. Different types of methadone programmes are described from low threshold programmes in some countries to high threshold ones in others.

Most countries have seen a rapid expansion in the provision of substitution services, especially in Spain, France, Greece and in some Central and Eastern European countries. A rapid expansion is even more evident in countries like Luxembourg, Finland and Greece, which had lower baseline levels of provision. The impetus for the expansion has largely been a response to the HIV/AIDS epidemic among drug users in the eighties. Whilst most countries have experienced few problems during this growth period, concern has been expressed in some member states. It concerned the lack of training and skills of some practitioners who are now involved in substitute prescribing.

The estimated number of addicts in methadone substitution treatment per 100.000 population aged 16-60 was reported for 1997 in a report of EMCDDA for the European member states. The numbers ranged between 6 (per 100.000 population aged 16-60) in Finland, Luxembourg and Greece, to 12 and 16 in Sweden and France, 33 in Portugal, 75 in Denmark and Germany, to between 96 and 145 for respectively the UK, Belgium, Italy, the Netherlands and Ireland, and finally up to 206 in Spain.

Inside prison this therapy has been widely introduced only in the nineties. In some countries there has been an increase of methadone treatment in prisons even since the mid-nineties and it is supposed that still the needs of prisoners are not covered (for instance in Spain, Delegacíon ... 1996).

Bossong (1995) considers the prison setting to be comparatively suitable for this method of treatment: "In prison the "classical" target group for methadone treatments (therapy drop-outs, offenders who are reluctant to live abstinently, who are physically and socially incriminated) is great. The drug-addicts can be reached at any time so that handing out of methadone at regular intervals and the urine tests required

can be carried out without any problem. The ultimate goal of imprisonment "to induce offenders to lead their life without committing further crimes" (which must not necessarily be equated with abstinence!) corresponds to the goals to be achieved by the methadone treatment." (14/15). It must also be assumed that inmates participating in a methadone treatment will become more receptive to services provided in detention. The treatment not only helps offenders to break away from the drug scene, to avoid other forms of addiction, but also makes them do without the very risky use of injection equipment.

Methadone treatment is a medically founded method of treatment which must be pursued irrespective of the patient's whereabouts. Reasons for interrupting the treatment should only arise from the medical or psychosocial context, however, not from control or punitive measures. The treatment is not a "special treatment" granted to those who have behaved well, but a treatment for sick people, which is used in more or less the same way as outside prison. Given a medical indication the offender is entitled to the treatment; the prison management may not refuse to grant it" (Kommission ... 1995, 73).

In the Turnbull/Webster (1998) study on demand reduction activities in the Criminal Justice System in the European Union, it is said that the prescription of methadone on a maintenance basis is available only in 4 European countries (Austria, Denmark, Luxembourg and Spain) and occasionally in Germany.

A discontinuation of methadone maintenance treatment started in the community when entering prison is still a fact in most of the EU countries (except in the above mentioned). Methadone maintenance treatment remains a controversial issue in many prisons, although the option of methadone-based detoxification is taken more and more by most of the EU countries as shown in Table 8. The more widespread methadone prescription is becoming outside the more widespread it becomes in prison although with slow progress in time. Muscat (2000, 14) draws the attention to the fact that although in some countries like France and Portugal theoretically these treatment options are available in prisons, it is not clear to which extent inmates demand them.

Provision of methadone treatment within prisons varies considerably across countries. Spain and Austria have high levels of provision. In Spain, it is estimated that 60 % of drug users in prison receive methadone. In Austria, maintenance treatment has been offered in all prisons since 1991, and social and psychotherapeutic approaches are also offered. On the other hand, prisons in Portugal do provide methadone and, in Belgium, Germany, Ireland, Italy, the Netherlands and the UK, provision is minimal, apart for when used for the purposes of detoxification. Sweden and Greece do not provide methadone in prisons. Eligibility for entering a methadone programme in prison largely depends on levels of treatment provision. In all countries where a programme is available, a user receiving treatment outside the prison setting can continue treatment inside. In the UK, where provision is low, it is estimated that a third of those who are receiving methadone treatment before entering prison also receive it in prison (e.g. Netherlands 28% to 4%). In Austria, Portugal, Spain and partly Germany, however, a drug user can begin treatment on entering prison.

Some of the basic problems of methadone treatment in prisons are nearly the same as outside years before, others are prison specific problems within the triangle of prison doctor/medical staff, personnel and inmates:

- Basic abstinence orientation: The time of imprisonment is seen by doctors and others as time to overcome drug addiction resp. to stay drug free. Methadone treatment in this philosophy is seen as prolongation of the addiction.
- The criteria for receiving a substitution treatment seem to many drug using prisoners quite unclear and intransparent according to a French survey: “In prison some people are regarded as patients and

others as drug abusers' (Trabut 2000, 30). This is due to the fact that some patients have been already in such programmes before, while some others haven't been. Because there is such a big difference sometimes from prison doctor to prison doctor within the same country, region, state or even city, for some prisoners the prescription of substitutes seems to be quite arbitrary.

- The provision of methadone treatment is dependent of the medical view of the prison doctors and the medical team within the specific institution
- methadone is often perceived by staff more as a gratification, more as a drug than a medical treatment and medicine (report from Italy). It is a classical harm reduction measure which aims at stopping the opiate addiction only in the second place. The prevention of drug related harm has priority. And staff member often judge critically about substitution treatment because of supplementary use of other (often illegal and injectable drugs).
- the above mentioned goal 'distance from the drug scene and the prison subculture' is hardly to achieve in a total institution like prison. The physical inevitability makes it extremely difficult to distance oneself from members of the local drug scene. In some prisons concepts of differentiation are implemented (Germany, Austria), where inmates receiving methadone treatment are separated in certain wings and get special support.
- Anonymity and confidentiality of this medically indicated treatment is also difficult to guarantee, because inmates in methadone programmes have to get through the whole prison every day to get their methadone dose and other medical and psycho-social support. So it is clear to everybody who is in a methadone programme
- Despite some studies showing that methadone treatment is non-disruptive and had a positive effect on prisoners' drug using behaviour (for Scotland: Shewan et al. 1996), constitutes a basis for further medical contact and treatment (Dolan/Wodak 1996), does have a significant impact on the reduction of the transmission of communicable diseases (Hall/Ward/Mattick 1993), the prevention of opioid-related overdoses and other advantages (see Verster/Buning 2000[47]), methadone is often seen a step towards allowing drug use and this form of treatment is often perceived as undermining the prisons efforts and strategies of an abstinence-orientation.
- the ambivalence of control concepts: the urine control and proof of positive test results by staff with consequences (loss of privileges) and the control of urine and proof of positive testing within a substitution treatment by the medical staff. Both control levels have to be kept disconnected with respect to the confidentiality of the medical services.
- the mode of detoxification dose and procedure is often topic of discussions. In some countries the steps of methadone reduction are criticised as too quick and too short (Italy, Germany). Often there does not exist a common protocol.
- in some countries (e.g. Spain , Delegacíon...1996) there is a lack of personnel, financial means and inconsistencies in the concept of methadone treatment
- Finally problems exist in take up, continuation of the substitution treatment on home leave/holidays, after release or after transfer into another prison and financing of this treatment form.

Substitution treatment in prisons is often integral part of a broader drug service concept, which also includes psycho-social support either from staff from inside or health or social worker from outside. It is aiming at different goals:

- to reduce the frequency of the use of injectable drugs and needle and drug sharing (medical purpose)
- to reduce the spread of infectious diseases and drug related harm (HIV, Hepatitis B+C, abscesses, overdoses, medical purpose)
- to reduce drug trade and smuggle in the prison (economic purpose)

[47] Methadone maintenance treatment has also proved to significantly decrease criminal activity, and to improve the quality of life of patients, including positive changes to health, employment potential, and social and physical functioning. Finally, oral methadone maintenance programmes have proved to be effective for the individual patient, for public health and in terms of cost-effectiveness

- a stabilisation of drug users being in substitution treatment already before imprisonment, especially during the entrance phase (medical/treatment-technical purpose)
- to reduce the development of prison specific and sub-cultural dependencies (prison specific purpose)
- to single inmates out of the prison subculture (social setting purpose)
- to give the basis for a transfer to an open prison (rehabilitative purpose),
- to improve the relapse work
- to prevent inmates from getting criminal again after release (criminal justice purpose)
- personal potentials of development should be promoted (rehabilitative purpose, see Ministry of Justice/Northrhine-Westphalia/Germany 1998).

A short overview of the prescription practice:

Austria: Since 1991, all prisons in Austria have been offering maintenance therapy with synthetic opioids during a prison sentence. Some prisons offer specific units for substitution (i.e. Stein 42 beds, Josefstadt 70-80 places; Eisenstadt with 15 places). The prison in Favoriten (Vienna) is specialised in the treatment of addicts. Amongst other offers prisoners might get substitution treatment but they can also acquire social and psychotherapeutic support, job qualifications in the form of an apprenticeship. These approaches are offered in addition to medical treatment.

Belgium: Methadone substitution can be continued in prison. For the moment this only concerns patients who were in substitution treatment before being incarcerated. At present, treatment in prison consists of progressive withdrawal, but it is anticipated that substitution will be initiated in prison for maintenance for specific groups. Since 1995, methadone has been used in some prisons. It should be noted that around one-half of prisoners have experienced problems related to the consumption of illegal drugs and that one-third have experienced heroin consumption problems.

Denmark: The number of drug users in prison has increased since 1986. Statistics regarding drugs and crime show that 35 % (1 300) of the prison population are drug users. The number of persons charged with drug-related crime was 8,700 in 1996. As a rule, co-operation between the criminal-justice system and the county treatment systems is good. Treatment is not disrupted because of imprisonment. Collaboration between the treatment system and the health service is more problematic. Drug users are, in practice, often excluded from in-patient care in particular, on the grounds that their behaviour is unacceptable. The policy of the Direktoratet for Kriminalforsorgen (Directorate for Prison and Probation Services) is that drug users in prison should be offered treatment co-ordinated with the social services and treatment institutions outside the prisons. Thus, in principle, treatment (including substitution treatment) should not be interrupted because of imprisonment.

Finland: Continuity of care has not yet been a problem during the three and a half years of the programme. Four patients of the substitution treatment clinic continued receiving methadone substitution while in prison in 1998. The Ministry of Social Affairs and Health regulations refer to LAAM as a substitution substance, but it is not used in Finland. It is estimated that around 170 opiate addicts in Finland have been receiving buprenorphine.

France: According to the results of a survey carried out by the Ministry of Health in 1998 substitution treatment discontinuation is a major problem: 22% of new inmates taking buprenorphine and 13% of those taking methadone have ceased during within 8 weeks of incarceration. The principle of continuation of treatment in prison, affirmed in the circular of 11 January 1995, was defined by the circular of 5th December 1996 which states that substitution treatments may be continued or started in prison with methadone and Subutex®. When a substitution treatment in prison is started, the initial prescription of

methadone must be made by an internal or external CSST. The medicine must be dispensed by the medical staff. To facilitate the integration of the correctional health service into the care system, a doctor practising in prison must be included on the departmental monitoring committee. The doctors of the prison's internal medical services are invited to contact the attending physician and to organise the continuation of treatment after release. There is a continuation of treatment on release: 95% of former prisoners taking methadone and 79% of those taking Subutex® receive medical support on leaving prison.

Germany: Currently, no exact figure of methadone patients in penal institutions is available, estimations are around 800. Only 6 out of 16 federal states provide methadone treatment in prisons (Berlin, Bremen, Hamburg, Hesse, Lower Saxony and North Rhine-Westphalia) predominantly for detoxification purposes. Through prescription or methadone maintenance is poorly developed (Keppler 2000). Entry criteria as well as detoxification procedures vary considerably between states, and substitution treatment is not available in all of the prisons of these states (Keppler and Stöver, 1997).

Greece: no methadone prescribed in prisons at the moment

Ireland: In theory, prison policy is to provide the same level of substitution treatment within prison as without, but in practice this does not happen. There is one detoxification unit and one small maintenance clinic in the largest prison (with approx. 20 prisoners on this programme at any one time). "There is a standard detoxification programme of 14 days, which is offered to prisoners on committal if they are found to test positive for opiates. Prisoners that may have been stable on methadone in the community are generally detoxified upon incarceration" (Dillon 2000, 39). Due to the Irish Prisons Service the situation has changed considerably. Methadone maintenance was introduced in early 2000 to the new remand prison at Cloverhill (capacity up 400 places) for prisoners who were on maintenance programmes in the community. This development has now been extended to the largest prison in the state, Mountjoy Prison (capacity 670) at the end of 2000. For those not being in treatment before arrival in prison, in certain circumstances, (for ex. HIV positive) a substitution treatment can be commenced in prison.

Italy: Substitution treatment is received by only 500 drug users out of the total 14 000 in prison (as of December 1997). Lack of continuity of treatment between the healthcare system and prison is also a major problem.

Luxembourg: Clients who are in methadone treatment before their detention continue their treatment during remand and, in cases of a long prison sentence, undergo slow detoxification. A prisoner is allowed methadone before his release.

The Netherlands: Almost all IAVs (16 Instellingen voor Ambulante Verslavingszorg (IAVs) (Institutions for Ambulatory Addiction Treatment and Care) offer a maintenance and a reduction programme. Over two-thirds of the clients attend maintenance programmes. One exception relates to programmes in detention centres, where addicted prisoners who will spend more than a few weeks in detention are obliged to follow a reduction programme. From the wide range of projects and facilities that have been set up, some appear to function well, though others have been disappointing or have led to unexpected results. The Intramurale Motivatie Centra (Intramural Motivation Centres), and, in part, the projects that encourage addicted prisoners to be treated, are examples of this. An important conclusion is that no policy can be truly effective unless there is a degree of coherence and compatibility between the facilities. To prevent a situation arising where a client is not accepted by any of the facilities, continuous monitoring will be essential, which in turn requires a co-ordinated approach and supervision of the various facilities.

Portugal: Where methadone units are available, prisoners sign a treatment contract; in prisons with no methadone unit, prisoners are followed by the nearest treatment centre from the Ministry of Health (CAT), and by agreement between the two services are treated using either methadone or LAAM

Spain: The 1990 law included a paragraph on methadone use in prisons and, in August 1997, all the prisons except two had already developed methadone-maintenance programmes. Data of August 1997 showed that 11 605 (27 %) prisoners were enrolled in methadone treatment. Most cases (86 %) were men, with a mean age of 29 years. Seropositivity to HIV infection was found in 66 % of the cases, to hepatitis B virus infection in 79 % and to hepatitis C in 70 %. Most subjects (84 %) received a daily dose of ≥ 60 mg of methadone. Methadone maintenance programmes were not abstinence-oriented, they prescribed a mean dose of ≥ 60 mg/day and there was no time limit on treatment. In most centres, when treatment for tuberculosis was indicated, anti-tuberculous agents were administered together with methadone. When subjects are discharged from prison, they are referred by the prison to continue methadone-maintenance in an outpatient centre.

Sweden: Methadone maintenance treatment is not available in Swedish prisons since one of the inclusion criteria for maintenance treatment is that the patient shall not be in custody, under arrest or in prison at the time of admission.

UK: There has been considerable expansion in the growth of methadone detoxification for prisoners in England an Gales, but only a very limited amount of methadone maintenance (Singleton et al., 1998). Substitute prescribing is one of the most common forms of treatment delivered by community treatment agencies. There is a very low level of continuity between community methadone treatment and prison methadone treatment. Data indicate that, for those who are sentenced, there are reasonable levels of contact with outside specialist agencies. Short term methadone detoxification is the most widespread approach concerning drug users. In the women and juvenile prison 'HMP Holloway' in London/UK for instance annually 1,500 withdrawal treatments are carried out (approx. 530 prisoners at any time; pers. communication). In Scotland the methadone maintenance programmes are reflecting the prisoners specific conditions (clinical profile, judicial and penal situation). Then communication with the community prescriber is made to confirm dosage, compliance and willingness to continue prescription on liberation (Scotland Prison Service 1999). The maximum dose is 60 mgs daily in Scotland. If a prisoner on a community methadone programme will be in prison for more than three months a reduction programme may be prescribed to this group if some conditions are met (10.4):

- Urine will require to be dipstick tested on the day of admission
- Urine analysis will reveal the presence of methadone
- Urine analysis will not reveal the presence of any illegal or illicit drugs, or any medicines which have not been previously prescribed.
- Clinical examination will reveal no signs of recent injection sites. If necessary, a body chart may be completed for future reference so that new sites may be positively identified.
- Contact should again be made with the prescriber in the community and the prescriber informed of the plans for methadone reduction.
- Consideration should be given to the use of Lofexidine (...) if it is felt this is more appropriate.
- If methadone is prescribed, the community dose should be initiated up to a maximum of 6o mgs of methadone daily.
- Methadone reduction should be effected by decreasing the prescribed dose by 5mls per week to 20mls.
- Thereafter the dose should then be reduced by 2mls per week until the prisoner has been detoxified, or detoxification with Lofexidine offered at this point.

“Actually, these policies have not yet been evaluated and it is not possible to assure their widespread implementation. Beside official approval, it is essential to evaluate the agreement of health workers with such a policy. The field experience tend to show that some health workers, in France for example, do not believe in the efficiency of methadone programmes and favour all full withdrawal. We need on the one hand to identify the level of and the nature of resistance to drug treatments among heath workers and prison staff, and on the other hand to have reliable evaluations of harm reduction strategies in prison.” (Rotily/Weilandt)

For Scottish services the specific conditions are relevant for the mode and length of treatment. Nick Royle from the Scottish Prison Service (2000) illustrates that by giving a case description for the situation in Scottish prisons:

"A prisoner comes into a local prison on remand. He is prescribed methadone in the community, and is found suitable to continue that prescription in prison (i.e he is not topping up, and the community prescriber undertakes to continue prescribing on his release), and so he is given a reducing dose, stabilising on less than 60 mgs daily. His case is heard at court and he receives a sentence of 2.5 months to serve, and so his prescribed methadone continues at the set level. He has a further case heard at court, and receives a sentence of 1.5 years to serve. His methadone is therefore reduced in dosage by 5 mls per week to 20 mls, and then by 2 mls per week until detoxified, or Lofexidine offered. At any point after sentence he may be transferred to a long-term prison, and his dosage regime will continue until complete.

If the same prisoner had come into prison as a chaotic user not compliant with his methadone script (or not prescribed methadone), he would have been offered a detoxification regime of Dihydrocodeine Continus and Diazepam, or Lofexidine and Diazepam, reducing over 30 days.“

Methadone prescription in prison has always be set into relation to the general prescribing policy outside. In those countries or states, where substitution treatment is common and widely adopted outside, prison doctors more and more apply this form of treatment inside. If substitution treatment is adopted it is done in various forms, also common outside: as means in a detoxification process (often precisely described in which form and time) and as maintenance either through-prescription either in short term or long term sentences (with a medical indication), or as relapse prevention treatment (with a more social indication) before a certain period of time before release.

The substances prescribed are equivalent to those outside: methadone, buprenorphine, morphine, codeine. But mostly there is a difference in adopting the whole variety of substances used outside: inside the prison often the variety is reduced to only one substance (like in Austria: outside available substitute substances like morphine, buprenorphine and codeine) are not used in prison.

The following table gives an overview, although it cannot reflect the whole complexity of the topic:

Table 7: **Scope of Substitution Treatment in Prison**

6	Detoxification	Maintenance		Relapse Prevention	Substitution substance predominantly used	no. of inmates in methadone programme
		short term prisoner	long term prisoner			
Austria					Methadone	345 (11/2000)
Belgium [9]					Methadone	
Denmark[14]					Methadone	1999: 290 inmates in maintenance methadone programme
Finland, [15]					Methadone, Buprenorphine	8 (1998)
France [11], [16]					Methadone, Subutex® (Buprenorphine)	Subutex® (879) methadone (157) total: 1036 in March 1998
Germany					Methadone	approx. 800
Greece[12, 15]						
Ireland [6]					Methadone	53 in Detox. Units (mostly Closed Male Remand and Adult Prisons) 184 on methadone maintenance (6 Dec., 2000)
Italy [1, 2]					Methadone	939 (1,8%)[3]
Luxembourg					Methadone	
The Netherlands [7, 8]					Methadone	
Portugal[48], [10]					Methadone, LAAM	
Spain [13]						18899/1999 (Carrón 2000)
Sweden [15]						
England and Wales [4, 5]					Methadone mostly; Lofexidine in some; Dihydrocodeine	
Northern Ireland						
Scotland						

Few Prisons: **Most Prisons:** **All Prisons:** **No Prisons:**

[48] In the 'National Strategy on Drugs and Drug Addiction' a long term Drug Plan targeted to the prison system has been integrated (1999-2003). Within that it is planned to extend methadone maintenance and other treatment facilities (LAAM or Naltrexone treatment) to all prisons resp. to all inmates with clinical profile

Notes:

[1] Only in 2 prisons: Milano (Lombardia) Padova (Veneto)

[2] In Milano (San Virrore Prison)

[3] Direzione Amministrazione Penitenziaria del Ministero di Grazia e Giustizia (DAP) 31.12.99

[4] This will be addressed in the Revised Healthcare Standard No.8. The Prison Health Policy Unit is now working, with the assistance of NHS specialists and others, to revise Standard 8. The new version of the Standard should include a significantly expanded section on the management of prisoners who have been receiving methadone in the community, and on their throughcare.

[5] Naltrexone available in some12 Step Programmes.

[6] In general prisoner will not have maintenance initiated in the prison setting, but if they were on a methadone programme in the community it may be continued upon imprisonment.

[7] less than 4 weeks imprisonment

[8] almost all, but only for special reasons: addicted a long time, mental health problems

[9] mostly 4 weeks, only available to drug users who were already in a methadone-programme before their incarceration and after confirmation by the external doctor

[10] There are three prisons with methadone in-treatment units (1 in Lisbon, 1 in Porto, 1 in the female prison of Tires). When prisoners enter in prison, there is a continuity of treatment in case they started before. The same occurs after release where treatment is provided by agreement with the drug treatment centre from the health state network (CAT) in the prison area.

[11] A legal regulation from 5th of December from the Ministries of Justice and Health made substitution treatment in prison possible, maintenance as well as start of prescribing. In 1998, forty-four prisons (out of 187, Heino Stöver) offered no prescribed drug substitutes to prisoners at all.

[12] The Ministry of Justice will develop a substitution programme for drug addicted prisoners in the near future (OKANA, personal communication 27.6.2000)

[13] In Spain there are differences in the provision of methadone from region to region. In Catalan prisons approx. 1,000 prisoners receive methadone out of a total prison population of about 6,000. The methadone prescription is common in all prisons. For detoxification other opiates are used, mainly dextropropoxiphen. In Spain (without Cataluna) the figures of inmates being in methadone treatment are rising considerably from 696 in 1994 to 18999 for the total year 1999 (Carrón 2000). At 31/12/1999 6 589 inmates received methadone (17,21% of the total prison population at that time).

[14] According to the law the county council has the over all responsibility for substitution treatment in Denmark. Prisons are therefore instructed that decisions about treatment of drug addicts with methadone should be made in co-operation with the local county council drug treatment authority. Prison doctors do however have the final responsibility for the medical treatment of the inmates.

[15] In Greece and Sweden methadone prescription in prison is not available. In Finland methadone/buprenorphine has been introduced only in 1998: The first prisoners in withdrawal or substitution treatment with opioid preparations according to the directions of the Ministry of Social Affairs and Health arrived in prison in spring 1998. During that year the number was eight persons (three of them in substitution therapy with methadone, five on buprenorphine; Mäki 2000). Detoxification with methadone and substitution treatment can be given in any prison, but the assessment has to be done in a drug treatment unit outside. So far only treatment started before imprisonment is continued

[16] Around a thousand people (i.e. approx. 2% of the total prison population) received methadone treatment in French prisons in March 1998, of which slightly fewer than one in five started that treatment in prison. By the first of January 1998 10 547 people were held in French prisons for drug related offences (Focal Point France).

III.5.1. Key issues of methadone prescription

The principle of equality of the health services inside and outside prison is reflected in the recommendations and requirements of many international commissions (WHO, Council of Europe) and experts. However, there are several important distinctions with regard to the use of substitute treatment especially methadone maintenance treatment within prison:

- Outside prison, patients in methadone treatment are often required to dissociate physically, socially, and mentally from the drug scene, which, until then, was the focal point of their lives and personal experience. Behind bars, this disassociation is only possible to a limited extent.
- Effectiveness and attraction of maintenance programmes depend on the positive attitude of the treatment staff as well as on the entry threshold level. The prison system often has problems with both of these conditions.
- Where politicians and the public are concerned, methadone maintenance was linked to expectations which were partly unrealistic and which exceeded medical outcomes. These expectations were not fulfilled. The large-scale distribution of substitute drugs was supposed to have a widespread effect which - in addition to medical and social stabilisation - should eliminate drug subcultures and drug scenes in and outside prison. The outcome, however, mostly fell short of expectations.
- Maintenance is considered very time and labour intensive, particularly in the starting phase when treatment- and medical staff have to acquire the necessary ‘maintenance know-how’. This can sometimes be an arduous process. However, methadone maintenance remains costly throughout the programme, i.e., when the number of methadone patients increases.
- Methadone maintenance is still approached in entirely different ways across the nation. It varies from state to state and even from prison to prison.
- Drug testing for the additional use of psychotropic substances is mandatory for all methadone patients. This also applies within the prisons. Due to a variety of manipulation techniques in urine testing, usual testing procedures should be interpreted with great care.

There is a consensus both outside and inside the prisons that besides providing the substitute drug supporting psychosocial measures is sensible and can contribute to achieving therapeutic objectives. However, experts disagree about whether **psychosocial support** is an indispensable and obligatory part of medical maintenance treatment or whether it should be offered as a voluntary service to those concerned. Often the prison system already has the staff as well as the instrumental and organizational resources necessary for providing psychosocial support.

Even if maintenance behind bars is frequently seen as a mere improvement of ‘misery management’, i.e., as a sheer harm reduction tool and not as a measure suitable for solving the dilemma of a prohibitionist policy, it still is useful and necessary on practical grounds alone. Since methadone maintenance is known and accepted in the community, drug-dependent persons may develop an interest in maintenance treatment during the phase of internment. Prison medicine should be responsive to such wishes. In principle, methadone maintenance is a form of treatment that is particularly suited to the correctional system. On the one hand, most of the resources needed for maintenance treatment and psychosocial support are already available. On the other hand, prisons are filled with precisely the kind of clientele that comes into consideration for methadone maintenance, i.e., opiate dependent intravenous drug addicts with prolonged drug careers and various unsuccessful attempts to achieve abstinence. Maintenance treatment could be a stepping stone for further treatment. It is extremely important with regard to the new treatment options for HIV/AIDS and hepatitis. Often the phase of internment is also a phase of new health awareness, in which methadone maintenance helps to achieve better compliance with the new treatment.

Low threshold programmes like implemented outside with the following criteria formulated by Verster/Buning (2000) are not to be found inside prison: Low threshold programmes:

- are easy to enter
- are Harm reduction oriented
- have as primary goal to relieve withdrawal symptoms and craving and improve the quality of life of patients
- offer a range of treatment options

Looking at prescription criteria it becomes evident that methadone prescription is not perceived as a measure of harm reduction. Polyvalent users and users of other drugs are excluded for instance in the Standards for England/Wales: By means of urine analysis the presence of any other illegal drugs or any medicines which have not been previously prescribed, or clinical examination will reveal signs of recent injection sites.

In a few countries where methadone or other substitutes are prescribed in prison, there is a continuity of treatment in case they started before. This continuity of treatment is pursued for the period after release with the community services (for instance Portugal, cf. Celso Manata, 10.7.2000; Austria, Bundesministerium für Justiz 1997, in some countries it is a 'conditio sine qua non' i.e. Denmark; Reventlow 2000) or formulated as standard: 'Prior to liberation contact must be resumed with community prescriber to confirm throughcare arrangements and the continuation of the Methadone prescription'. (UK Standards for the Health Care of Prisoners). But often here are major obstacles in financing or even finding prescribing doctors outside (for Germany: Keppler 1997).

The remarkable point is that the number of methadone patients decreases dramatically when drug users enter the prison system: In the Netherlands for instance about 28% of the registered drug users receive methadone, while in prison only 4% of the detainees do so. (Zorg Achter Tralies 1999, quot. in van Alem 1999, 8). This is confirmed by figures from France: While outside prison approx. 37% (60,000 out of 160,000) of opiate users are being treated with drug substitutes, only 2% of all inmates are in substitution treatment, although 14,4% of new inmates are active opiate users (see Trabut 2000, 29f). Also for Germany this decrease can be observed: out of 150 000 addicts of hard drugs, some 50 000 (33%) receive methadone or codeine. Inside prison approx. 800 prisoners receive methadone on a maintenance basis. In prison only about 12,5% of those continuing drug use in some way or the other (10 000 = half of the estimated drug using inmates) get this treatment. There seem to be great regional differences in the continuation of substitution treatment (French Focal Point 2000 report that in France while some single prison services in France account for approx. A third of all prescriptions others (more than a quarter) had no patients at all under substitution treatment.

That means methadone is predominantly used as a means of detoxification, while long term prescription is only done in some countries not necessarily covering all prisons for a few target groups, like in the Netherlands for:

- drug users with a short stay
- drug users with a long addiction career
- drug users with severe mental health problems.

The issue of 'through-prescription', methadone also for long-term sentenced prisoners remains controversial: In some states this is clearly denied and clear protocols for detoxification have been

developed (for the UK[49]), in other states this is offered normally in most (Austria) or occasionally in some of the prisons (Germany) or in some states within a country (i.e. Hamburg and Bremen/Germany).

There are still differences in the specific mode of prescription: whether there is a continuation of outside initiated treatments (like in Austria, Denmark, some states in Germany) or this treatment has started inside as a medical treatment or as a relapse preventive measure in the process of preparation for release (Germany). While starting a substitution treatment in prison is explicitly included in legal regulations (France: Circulaire DGS/DH/DAP du 5 décembre 1996 relative à la lutte contre l'infection par le VIH en milieu pénitentiaire), this form is explicitly excluded in some other states.

For the French situation the national Focal Point (1999, 63) reports: The conditions under which the patient's needs are assessed when deciding to pursue substitution treatment or not seem to vary considerably: no information is available on clinical evaluation, time taken to start treatment, methods of checking statements with the attending physician, taking the patient's point of view into account etc.

In some states in Germany it is possible to continue a methadone treatment that has been started prior to imprisonment and will be continued after detention. However, this is mostly restricted to short-term detainees in order to "bridge" the time in prison. Long-term methadone treatments are rejected by most prison doctors in Germany, only in the city states of Hamburg and Bremen this through prescription is followed. Some penal institutions offer a "gradual withdrawal". Sometimes drug-addicted inmates who are assumed to become heroine users again after imprisonment and for whom a treatment outside prison has been planned, are permitted to start a methadone treatment shortly before their prison sentence is completed in order to prepare them for the time after detention and to improve their chances.

Chorzelski (2000) emphasises the necessity of close co-operation between methadone treatments in prison and in the community on all three levels of methadone prescription in prison (Detoxification, initialising and through prescription. In the German city-state of Hamburg, in a close co-operation between the Department of Justice and the Methadone-Maintenance-Clinics of Hamburg, the medical controlling was shifted from the Department of Justice but by the Methadone-Maintenance-Clinics of Hamburg in order to increase the compliance of treated inmates. "To continue Methadone-Maintenance treatment of arrested patients, who had been treated with Methadone before they came into prison is a very important chance for this high risk group of patients, because more then 90% of this group used a lot of other substances of abuse beside Methadone. A very rigid regulation of Methadone-Maintenance brought for them the experience how life can be just to use Methadone and nothing else."

After detention methadone treatments must be continued without interruption. Thus inmates/drug counsellors should have the opportunity to make the necessary arrangements prior to completion of the prison sentence.

Inside and outside prison psychosocial care is a useful addition to the project and is crucial for opening up new prospects. Furthermore prisoners should have access to working and educational programmes and discussion groups to stabilise them socially and prepare them for the time after detention. The psychosocial care provided should be adjusted to the situation and requirements of the individual prisoner.

[49] Advisory Council on the Misuse of Drugs' in the UK (1996, p. 112) recommends: „We recommend that structured methadone prescribing regimes should be available to short-term and remand prisoners. We suggest that a maximum period of three months should be set for such programmes as we do not see long-term maintenance as feasible within the prison setting as a general rule, although it may be achievable in some establishments".

What are the reasons for discontinuation of methadone treatment even in countries where methadone is extensively used outside prison? Some explanations have been given by experts:

- abstinence orientation being still dominant in the medical approach, using time of detention for detoxification and experience of living without 'drugs'
- some inmates don't declare being in methadone treatment when entering prison to hide a drug addiction fearing disadvantages of this status
- The Ministry of Health of France is arguing that a treatment with drug substitutes outside facilitates a social rehabilitation and therefore fewer drug users with a substitution treatment are to be found in prison (Trabut (2000, 30). Those drug users in prison hence represent those for whom these social rehabilitation programmes either failed or haven't been applied for. Drug users in prison then represent a disintegrated and socially deprived group.

If the latter explanation is true, prison then would be a good opportunity to start substitution while in prison and to make use of the medical services within the prison. This point is also raised by empirical data from Scotland indicating that a high percentage of drug users in prison get into contact with the medical/therapeutic service for the first time in prison (Shewan 2000).

Apart from these arguments there are reservations against substitution treatment in prisons that derive from the specific national situation. For France with an extended Subutex® (tablets) prescription outside the National Focal Point (1999, 63) states: "The main reservations of care personnel working in a correctional environment relate to practices of misuse, which are more important bearing in mind the respective galenical forms for Subutex® (tablets) than for methadone (syrup the administration of which is supervised). The practice of « fiole », the dispensing of crushed and diluted products, is now much less common, the dispensing of crushed tablets, which is considered patronising, is rare, dispensing often still takes place daily and administration is supervised. This supervision, however, is not very effective in the case of tablets for sub-lingual absorption. Conversely, some teams try to run their practices like those outside prison and dispense Subutex® twice a week after one week of daily dispensing. There are also fears concerning the inhalation of crushed tablets. In more general terms it is the principle of substitution treatment itself and its appropriateness in a prison setting that present problems for the teams. Finally, dispensing by care personnel can mean a very heavy workload".

III.5.2. Standards and guidelines for methadone prescription

In many guidelines, i.e., standards for maintenance or psychosocial therapy, prisons are often excluded. A step towards the standardisation of maintenance treatment was made at the conference of the 'European Network on Drug and HIV/AIDS Services in Prison' from 12-14 March 1998 in Oldenburg, entitled 'Prisons and Drugs: Towards European Guidelines' (see Annex 1). Besides drug-free programmes, peer-support concepts and needle exchange, maintenance treatment was a major focus of this working conference.

The increasing number of methadone patients and the above mentioned problematic issues of methadone prescription in prisons are the major reasons for formulating guiding principles and concrete description of how to deal with methadone in prison. But only in some countries the formulation of general standards or more concrete guidelines has been carried out. In many other prisons it is left up to the responsible doctors. Although the doctor in every prison is free to prescribe methadone for therapeutic

purposes or not, standards or guidelines with a regional, national or even international scope are seen as essential and fundamental for any prescription policy.

In some countries guidelines for substitution treatment in prison have been developed in close connection to the relevant guidelines outside. Austria for instance has clearly defined how, for whom, with which substances a substitution treatment in prison has to be carried out. It is stated in the guidelines that basically substitution treatment should be possible in every prison. The guidelines list up the target groups of prisoners who may receive a methadone treatment:

- AIDS-diseased patients
- patients with a long history of drug use, who declare not to be able to live without drugs,
- patients who are awaiting an out-patient drug free treatment
- patients in long persisting crisis situations, which may occur during imprisonment (Bundesministerium für Justiz 1997, 4).

In these guidelines it is clearly indicated that methadone may be prescribed only by a doctor who is experienced in treating drug addicts. All three forms of methadone prescription in custody are described:

- as detoxification (reducing the dosage in regular steps)
- as maintenance for an indefinite period
- as a treatment form initiated in custody.

For the latter form the Austrian guidelines recommend to prescribe only to inmates who do have a long history of drug use with several and unsuccessful detoxification therapies, organic diseases, HIV-infection and a general bad health state are an additional reason for a medical indication. It is pointed out that a methadone prescription in the phase of preparation for release may be a useful measure of relapse prevention.

The Standards for the Health Care of Prisoners in Scotland contain clear and transparent substitute and detoxification prescribing guidelines for specific target groups with different length of sentence:

- Prisoners admitted from the community on a methadone programme who are expected to be in prison for three months or less
- Prisoners on a Community Methadone Programme who will be in Prison for more than three months
- Prisoners stabilised on a community methadone programme who occasionally use illicit drugs but do not inject
- Chaotic Drug Misusers
- Pregnant Drug Misusers.

In some of the countries in which substitution substances are prescribed in prison, there is no standardised prescription policy or written guidelines, or it varies from state to state or even from prison to prison within a state (i.e. Germany with a big North-South-gap, see: Stöver/Keppler 1998). At a hearing of the Ministries of Health and Justice in August 1994, methadone maintenance in prison still proved controversial; positions on social indication differed decidedly. To give examples on how differently methadone prescription policies may be in a federally organised country (16 Länder): Some of the participants of the hearing favoured an expansion of maintenance programmes in order to achieve a reduction in the demand of drugs, reduce crime in prison, achieve psychological, physical and social stabilisation as well as reinforce the motivation for abstinence. The representatives of Bavaria and Baden-Württemberg agreed that in individual cases the maintenance treatment could be continued if it existed

prior to the person's imprisonment. Both states generally lay emphasis on prison doctors being able to act on their own responsibility but immediately limit this medical liberty by issuing guidelines. For Bavaria, a larger number of patients in terms of a methadone programme is out of the question because of considerations to do with principle. Bavaria also favours the so-called 'cold-turkey' detoxification instead of methadone-based withdrawal. In principle, Saarland and Schleswig-Holstein are inclined to implement maintenance treatment with respect to preparing inmates for their release from prison, while Rheinland-Pfalz argues that drug-dependent persons in prison are usually detoxified already and that maintenance is therefore pointless. In Schleswig-Holstein, a decree providing for maintenance treatment was issued by the Ministry of Justice; methadone maintenance therefore has political backing. However, the representative from Schleswig-Holstein indicates that maintenance treatment in prison is not implemented often enough. Methadone maintenance has been adopted by the city states of Hamburg, Bremen, Berlin.as well as by the Länder of Lower Saxony, Hesse and North Rhine Westphalia. In terms of addict numbers, the drug problem in Germany's five new states is only small. Hence the use of illegal drugs in prison is low and maintenance treatment is therefore not administered often.

On the basis of a basic legality of the substitution substance, it is left up to the 'therapy freedom' of the doctors to prescribe in prison or not. They are mostly free to decide which prescription policy they adopt. Even if there are protocols for the treatment of drug addicted prisoner they need not necessarily to follow these recommendations. In some other countries precise protocols for prescription have been developed, like Austria (see 3.4.2.2.). In the Netherlands 'handreiking' (assistance guidelines) have been developed by the medical consultant of the National Agency of Correctional Services (DJI). As an example for the attempt to standardise methadone policy on a national level, the scheme is presented here (Doorninck 2000):

- Maintenance for those on remand or with a short sentence, who have been maintained on methadone in the community and evidence if engaged in community treatment programme and who do not have evidence of using other drugs in addition
- Pregnant women
- HIV positive and terminally ill who are on methadone maintenance

Medically indicated is the initiation of methadone prescription in prison in England/Wales only in exceptional circumstances, i.e. pregnancy or new diagnosis of HIV infection.

Comparing both standards with each other brings about some differences in the time span, when methadone prescription is continued: in the Netherlands for not more than 4 weeks and in England and Wales for prisoners who are expected to be in prison for 12 weeks or less (an exception can be made if the prisoner receives subsequently an additional short term of imprisonment while in methadone programme - then it is anticipated that methadone will not be continued for more than six months from initial committal to prison). The drug prescribed must be on a supervised and most important individual dose basis, within a safe and secure environment.

European Methadone Guidelines could also be relevant and basis for prison-based projects: Methadone treatment services are organised in a variety of ways throughout Europe. Sometimes, local legislation only allows specialised centres to prescribe methadone while in other places general practitioners and community pharmacies are involved. One argument at hand is whether methadone treatment is considered a specialised service or part of primary care. This depends on local legislation and on the way health care is organised in a given area. Another argument is whether methadone treatment is based on prescribing or dispensing.

When a treatment system is developed in any country, it should be planned as an integral part of the community's overall resources to deal with health and social problems. It should be 'population-based' (WHO Expert Committee on Drug Dependence, 1998).

This chapter focuses on the elements that are vital in organising best practice of methadone treatment. The elements discussed include staff requirements, the role of other services and the physical setting of programmes.

Staff requirements

There is considerable variation across countries as to who can prescribe methadone medication for the treatment of drug dependence. Nevertheless, it always involves a medical doctor, be it a specialist, general practitioner or psychiatrist.

Training

It goes without saying that a medical doctor needs to be knowledgeable about specific issues related to opioid dependence in order to be an effective clinician. Training programmes are essential so that the doctor is equipped to carry out good clinical practice. Whether these training programmes are organised as part of the general training of doctors or only given to those who start working in the drug field remains open and dependent on the local situation. Obviously, the best practice would be a combination of the two. Medical schools should include drug dependence and the different forms of treatment in their curriculum. A specialised training programme should also be available to doctors who are about to start working in the field of drug dependence and methadone treatment.

Training possibilities are equally important for all other staff involved in the treatment of opioid dependence. The content of these courses should include the pharmacological, toxicological, clinical as well as psycho-social aspects of opioid dependence. Regular seminars, supervision and communication with colleagues always form an essential part in keeping abreast of current developments in any field of medicine.

Team work

Medical practitioners in prisons (as well as outside) should not prescribe methadone in isolation. A multi-disciplinary approach to drug treatment is essential, which will include the staff of relevant treatment programme (social workers, counsellors and probably a psycho-therapist), nurses and administrative personnel. A full assessment of the patient, together with other professionals involved, should always be undertaken and treatment goals set.

Good management includes factors which are relevant to any type of organisation where people work together and where clients are involved. A clear description of each position including an detailed list of tasks are vital, as well as regular supervision. Regular team meetings will facilitate collaboration and case management of clients who need to see more than one staff member. Clear procedures within the programme are not only important for the staff but will also have an impact on the expected treatment outcome for the clients.

Role of the medical doctor

A doctor prescribing methadone for the management of drug dependence should have a deep understanding of the basic pharmacology, toxicology and clinical indications for the use of the drug, dose regime and therapeutic monitoring strategy if they are to prescribe responsibly. Irrespective of the composition of the staff of a methadone treatment programme, prescribing is the sole responsibility of the doctor. The responsibility cannot be delegated. It is the responsibility of all doctors to provide care for

general health needs and drug-related problems, regardless of whether the patient is ready to withdraw from drugs. It is the clinician's responsibility to make sure that the patient receives the correct dose and that efforts are taken to ensure that the drug is used appropriately and not diverted onto the illegal market. Particular care must be taken with induction, especially in case of self-reporting dosage, this can be clarified by the doctor prescribing outside. Clinical reviews of patients should be undertaken regularly, at least every three months, particularly of patients whose drug use remains unstable.

Role of the nurse

Nurses work with drug users in the medical units of prisons. Their skills and techniques range from assessment of drug users, counselling, health education and carrying out treatment procedures, such as dispensing medication. Some are also involved in wound care and the cleaning of abscesses. Often nurses are responsible for checking medication compliance and co-ordinate the case management. In some programmes nurses assume the final responsibility for the treatment.

Role of the drug worker/social worker/counsellor

Drug workers can come from a variety of professional backgrounds, such as nursing, teaching, social work and the criminal justice system. Their professional function can be considered as the major part of the full range of psycho-social services required for comprehensive treatment. Drug workers coming either from prison inside teams or outside charities and NGO organisations may provide support, give advice and basic counselling, and may act as a client's case manager or key worker. The latter combine inside and outside perspectives. The main function of a drug worker is to provide counselling to drug users and address family and personal relationships, child-care, housing after imprisonment, income support and probably further criminal justice issues. The professional competence and clinical effectiveness is closely related to training, competent supervision, formal accreditation and personal skills.

III.5.3. Provision of Original Substances in Prisons in Switzerland.

Since fall 1995 another remedial service - in addition to the methadone treatment - has been offered to injection drug users at the men´s prison of Oberschöngrün/Solothurn in Switzerland: controlled provision of opiates. The requirements for participation in the programme are similar to the high-level admission requirements for participation in the first methadone treatment in Germany 10 years ago: Minimum age: 20, a 2-year provable opiate consumption, unsuccessful treatments, medical-psychological and/or social deficits, minimum sentence: 9 months. Because of these "obstacles" therapeutic facilities are not used to full capacity (only 7 in 8). The programme is designed as a feasibility study of medically controlled provision of opiates in prison: The benefits and disadvantages of prescribing heroine are to be assessed.

Particularly the triple supply of heroine per day (maximum dosage: 250 mg, on average 125-200 mg for 100 Swiss Francs to be paid by the offender per month) which must be done under supervision, needs to be incorporated in every-day routine. Kaufmann/Dobler-Mikola/Uchtenhagen (2001) showed that the acceptance by staff was high and the goal of harm reduction was prioritised. The impact of the controlled heroin prescription on inmates' health and ability to work was valued positive. Despite the limited conditions under which the study was carried out (small number of participants, the special conditions in a penal institution, etc.) the project in Switzerland will give fresh impetus to the expert discussion of whether the supply of original substances is a suitable means to prevent the spreading of infections and if it is an effective measure of harm reduction among imprisoned injection drug users.

III.6. Harm-reduction measures

As Muscat (2000, 5) highlighted most of the recommendations (e.g. recommendation of the Council of Europe see Annex 5 and 6) of how to deal with drug users entering prisons propose medical treatments (like treatment for withdrawal symptoms) counselling (by internal or external specialists) and other services (psycho-social support either in prison or in the community) aimed at detoxifying prisoners. But several studies and international agencies (like EMCDDA) clearly show that a group of prisoners continue their use of drugs and this includes also injectable drugs while in prison. As showed already drug use frequencies and patterns change, though a substantial part even continues the use of injectable drugs. Despite all efforts of supply reduction reality is that drugs can and do enter prisons.

Being confronted with the same development outside prison harm reduction measures have been developed successfully in the past 15 years throughout Europe as a supplementing strategy to the existing drug free oriented programmes. Therefore it has to be discussed to which degree these successful and practically proven measures can be applied also in the prison setting, which for those prisoners continuing their habit has been proven to be a high risk environment.

Harm Reduction strategies aim to reduce the nature and extent of adverse consequences of drug use. Just as in the case of sexual transmission, the prevention of transmission through drug injecting calls for a comprehensive approach. Harm Reduction does not replace the need for existing interventions but adds to them, and should be seen as a complementary component of wider health promotion strategies.

These strategies are based on the following premises:

- drug addiction is curable;
- "harm-reduction" strategies are particularly important because certain infections related to illegal drug consumption (e.g. HIV or hepatitis C infections) are incurable and thus pose a threat to existence.

Before the background of these premises support to drug consumers should be provided according to the following list of priorities:

- securing survival;
- securing survival without contracting irreversible damage;
- stabilising the addict’s physical and social condition;
- supporting the addicts in their attempt to lead a drug-free life.

The support programmes launched so far which initially are designed to minimise damage, not only comprise crucial communicative strategies at the personal level (i.e. education and provision of information) but they also include instrumental measures. These will be described in detail in the next chapter. The goal pursued, i.e. to incite inmates to change their behaviour, can only be achieved if prisoners have sufficient room for movement. Improvement of the situation is impossible if this correlation between desired behavioural change and eased living conditions is not considered (for more details cf. Jacob/Schaper/Stöver 1996).

In Europe harm reduction measures are differently integrated into the prison environment. While O’Brien et al. (1997) state for Ireland that there are no harm reduction strategies in place in the Irish prison system, in some other countries harm reduction measures have been developed in the prison setting (Austria, Denmark, Spain, Germany). MacDonald (1999, 8f) found in her comparative study of the Prison Audits in 10 Italian and 10 English Prisons that for the Italian sample it appears that harm reduction

measures which are in place are geared towards those prisoners identified as known drug users. “This ignores the rest of the prison population who may either be ignorant of what constitutes risk behaviour or be engaging in risk behaviour (tattooing, sexual contact or injecting drugs)”.

III.6.1. The transfer of harm reduction strategies into the prison setting

Only a few prisons have been discussing drug use in their institutions and have adopted harm reduction measures which have been proven successfully outside. The main argument against the integration of harm reduction measures in prisons is that it would send the "wrong message" and make illicit drugs more socially acceptable. The necessity of harm reduction measures became extremely clear in HIV/AIDS-preventive strategies. Already in 1992 the WHO recommended a range of effective AIDS-prevention in prisons (Regional Office for Europe, 1992):

- measures to reduce the number of i.v. drug users in prisons
- measures to prevent drug use
- information about the risks of intravenous forms of drug application
- information about the risks of needle sharing
- demonstration of means of disinfection, provision of those means and means for an hygienic drug use (alcohol swabs etc.)
- provision of sterile syringes.

In most countries the provision of sterile syringes for instance is a highly controversial and politically loaded issue of debate. But also in countries where there are pilot schemes (like Germany, Switzerland, and Spain) this offer remains very controversial: while in three states ('Länder'; Lower-Saxony, Hamburg, Berlin) 7 pilot schemes have been developed since 1996, in other ‘Länder’ this is still discussed or in the majority of the 16 states is strictly rejected. Even in one and the same state there doesn't exist a uniform policy on this matter. Because of the fact that it is a controversial issue especially among the personnel of the prisons and their trade unions, for instance Lower Saxony prioritises a 'bottom-up'-strategy, that means pilot projects should be developed from the prisons themselves, with participation of management, staff and also inmates. In other states like Hamburg a 'top-down'-strategy led to problems in the transfer of politically driven decisions to implement such projects.

In other countries harm reducing strategies in all penitentiary centres shall be extended explicetely. For instance in Spain this is one goal that has been established by the Penitentiary Administration and the National Drug Plan.

What are the obstacles of a transfer of harm reduction strategies into prisons? Some problems are:

- harm reduction philosophy is in conflict with the goal of the sentence to be served namely to lead a life without criminal offences
- contradiction to the prison’s duty to care for all inmates either drug addicted or non-drug user
- dominating drug abstinence orientation which is identical with the goal of the imprisonment to lead a life without delinquent offences.
- contrary to the security task (fear of threatening scenarios, needle stick injuries etc.)
- no pro-active way of dealing with drug problems
- staff beliefs that harm reduction is the wrong and unclear message: it could be misunderstood by prisoners as a signal of legalisation or tolerance of prison drug use.

III.6.2. Blood Screening and HIV testing

Screening is done in most of the EU-prisons in the admission phase and on a voluntary basis. This is according to the WHO guidelines (HIV/AIDS in prison 1993). Blood screening is strongly recommended to prisoners mainly with tuberculosis. The findings of Todts et al. (1997) warrant a more generalised system of active detection of TB throughout the prison system (see chapter 2.4.3.).

In all countries of the EU, HIV tests are generally available for prisoners, mainly on admission. The screening seems always to be voluntary. In some countries, tests are offered systematically to all prisoners entering prison, while there are differences in how pro-actively this is done in practice. In other prisons, the test is only recommended for prisoners identified by the medical officers to be at risk. In the Netherlands and Scotland, prisoners are tested on their own request only. There are reliable estimates of HIV-test uptake-rates but the range is likely to be wide. In Germany, for example, it varies between 15 and 99 per cent depending on how the official testing policy is carried out in practice.

In most of the countries, prisoners are tested according to a clear protocol[50] with an informed consent procedure. The HIV test results are normally not communicated to the prison administration and are strictly confidential and kept in the health record. However, in some prisons, HIV positive results are communicated to prison directors. Laporte (1997) found in a third of 23 examined prison systems (in 20 European countries) where identity of seropositive prisoners is routinely communicated to prison administration. In seven other systems, identity of seropositive prisoners is communicated 'when necessary' to the prison administration.

In most regional states of Germany for instance the inmates are advised to take a voluntary HIV test at the beginning of their prison sentence. The legal authorities of the various states gather these test results and publish them in the Statistical Quarterly Surveys on HIV and AIDS Infections. However, it must be noted here that the results of the surveys are misleading because generally a considerable number of inmates refuse to take a test The testing practices within prisons in the various states differs widely. In some states test rates of more than 90 % have been achieved (e.g. Hamburg and Bavaria), while in other states (Bremen) no reliable data material is available because the tests are taken anonymously and outside prisons. To test inmates for HIV without their consent would counteract the liberal goals of the German health care policy which is designed to bring about changes in behaviour through education and providing information. Compulsory tests would be aimed at controlling and recording epidemics and at criminal prosecution. The practice currently applied in penal institutions, i.e. to give inmates the opportunity to take voluntary HIV tests corresponds to the practice applied outside prisons. Some inmates do not use the opportunity to take voluntary tests for fear that they will entail disadvantages during detention. On the other hand there are some states (Bavaria, Baden-Wurttemberg, Hesse, Saarland) where the refusal to take a test will definitely result in disadvantages during detention. Those prisoners refusing to take a test are treated as if they were HIV positive with respective consequences.

In a few countries, positive HIV tests have certain consequences for the prisoners. In some states of Germany (also in Greece) HIV infected prisoners can be placed in single cells, and if they want to share a cell with other persons, other inmates are informed about their serostatus. In some countries, HIV positive as well as Hepatitis B and C positive inmates are excluded from kitchen and/or barber work. Here again, the situation is difficult to evaluate, because within each prison system the directors have a discretionary power, which allows them to organise freely the placing of prisoners. In most countries the HIV-test (anonymously and free of charge) is strongly recommended to prisoners when entering prison (Ministère de la Justice/ France 2000).

[50] for instance in The Netherlands 'Protocol HIV-Testbeleid in Justitele Inrichtingen' from July 1994

In general HIV tests are not repeated at the end of detention so that seroconversions that may have occurred during detention are not recorded. The state of Baden-Württemberg is the only exception. Here a two-year test series was conducted, including repeated tests. The number of those refusing was low. If the states pursued the policy of conducting consistent follow-up examinations this would mean that an additional test would have to be taken after detention and after the time during which HIV-antibodies may be detected. Owing to the lack of longitudinally collected data on seroprevalence in penal institutions, the number of seroconversions during detention is unknown in most states. Only in Berlin and Hesse two cases in each state have become known during the past years (BMG 1995:9).

Besides, it must be pointed out that systematic testing is restricted to HIV infections, a procedure which reflects the fact that HIV is considered the greatest challenge in health care. However, particularly with injection drug users in prison the number of hepatitis infections is assumed to be considerably higher. The significance of this epidemiological fact has not been given adequate attention in public discussions and in expert discussions on AIDS. Only in recent years all groups involved have developed an awareness of the problem.

III.6.3. Training and seminars

The goals of training seminars for imprisoned drug addicts are:

- Demonstrating the service and help offers inside the prison system
- Arousing and stimulating the motivation to continue or take up treatment after imprisonment
- Thorough counselling on all possible forms of treatment
- Encouragement to contact counselling and treatment agencies that can treat the prisoners on their release
- Help with social, financial and administrative aspects of rehabilitation

Often counselling and support for prisoners is an concerted action of internal and external services (community based counselling agencies).

Cramer/Schippers (1994/1996) developed a **self-control information programme (SCIP)** which has been introduced to Dutch prisons. It is based specifically on the 'Harm Reduction' line of reasoning and aims to help drug users (not only users of illegal drugs) accelerate natural recovery processes by including the following components:

- Helping users to realistically assess both the advantages and disadvantages of drug use and those of 'kicking the habit';
- Helping them to view 'kicking the habit' as a process that can be gradual, rather than all-or-none;
- Helping users to view controlled use that is integrated within the context of a conventional lifestyle as a success in the right direction;
- Helping them to assess the present quality of their life and compare it with the life that they are striving for; and
- Helping them to formulate a step-by-step strategy for attaining the quality of life for which they are striving.

The programme consists of a self-help booklet entitled "Kicking the Habit: An upward Spiral", an exercise-book and an instructor's manual for counsellors who want to use the booklet in interaction with their

clients. These materials (used in a four-session format) are object of an ongoing body of research and are evaluated in all kinds of in- and out-patient treatment centres as well as in prison settings. The self-help booklet is pilot-tested in user- and parents group. Many concerned persons contributed to, gave feedback on, and helped to organize the various steps in development. They too helped to design its *background philosophy*, that can be described as follows:

- *A process-oriented approach with pragmatic content*

This means that it looks at kicking the habit not as an "all or nothing endeavour" but as a process, in which little by little progress is made in various dimensions of human life. According to this line of reasoning drug use reduction is not seen as the only goal of kicking the habit, but other goals such as better personal hygiene, a nice roof over one's head, restored relationships, and the building of a better structured life and a more productive lifestyle are viewed as equally or even more important.

- *presented as realistic and emancipatory*

In the programme kicking the habit is not viewed through rose colored spectacles. Information given is factual, objective and undramatized. From experiences of former drug users it has become clear that kicking the habit brings advantages but sometimes it brings even more disadvantages, so that is what the information is about. And a lot of people did not experience becoming and staying abstinent as an arrival in paradise, so that is not the way in which it is described.

From research results we know that for some people controlled use is perhaps a better option than total abstinence, but at this stage of scientific knowledge we can not determine which option is best for which individual. For that reason counsellors sometimes hesitate to talk about this option, out of fear that they will put wrong ideas into their clients' heads.

In the programme this option, the uncertainty about it and its advantages and disadvantages are openly talked about.

- *non moralistic*

In moralistic thinking addictive behavior is looked upon as the behavior of weak willed or bad people. And kicking the habit is viewed as an "all or nothing endeavour", with willpower as the only tool. "If you really want to get off drugs, then you'll manage to live without them" is the reasoning behind it.

In the programme addictive behavior is looked upon as rational and logical behaviour. Accordingly changing this behaviour is viewed as the result of a rational decision based on an evaluation of advantages and disadvantages. Information is given in a neutral tone. Suggestions are given about what drug users could do in certain situations, but no line in the booklet is telling them what they should or should not do. People are not forced in a certain direction, action or decision, but all those matters are left to their own free choice.

- *client-centered*

Kicking the habit is viewed as an individual and complex process. And in that sense for each individual it's important to consider his former experiences with relapse and recovery, his current position in that process and his feelings about which kicking the habit strategy matches best with his own unique needs/situation.

- *and drug addiction normalizing*

In the programme is emphasized that a drug addiction can be conquered in the same way as other types of addiction such as smoking and drinking, that are socially more accepted. The same principles can be applied to all types of addiction.

Peer education and peer support can be defined as: "the process on which trained persons carry out informal and organised educational activities with individuals or small groups in their peer group (persons belonging to the same societal group, for example of same age, doctors, prisoners, bankers or guards)"[51] Peer education has the overall aim of facilitating improvement in health and reduction in the risk of transmission of HIV or other blood-born diseases, targeting groups are individuals and groups which cannot effectively reached by existing other services. Sexuality and illicit drug use are two key areas which are highly taboo-loaded and which predestined for peer education and peer support activities. This is even more true for the prison setting.

The advantages of peer support in prisons are:

- users have personal interest to change situations
- users enjoy trust from their fellow inmates
- peers have first hand information (to avoid certain substances or mixtures)
- peers have authentic experiences (e.g. overdose, 'unsafe use patterns with hidden risks)
- peer support is a cost-effective now-ball strategy (see also Engelhardt 2000).

Prison Peer Education (PPE) was found to significantly contribute to changes in prejudices that inmates may have had towards HIV and people affected by it. For example a study of a PPE program in Australia concluded that a large majority of inmates (71%) felt that HIV positive inmates should not be segregated from the mainstream inmate population. Inmates had a relatively high level of understanding of the principles of HIV transmission, with over 98% of them knowing that they could not get HIV from activities involving everyday contact - sharing an apple or cigarettes, kissing, touching or using the same toilet. Furthermore 99.4% understood that you could get HIV if you undertook the high-risk activities of sharing needles and having sex without condoms[52].

Next to education by and for inmates (e.g. in HMP Holloway/London), health promotion could be conducted by municipal organisations operating outreach activities (among injecting drug users). 'Mainline', a Dutch health and prevention organisation maintains contact with detained drug users by low threshold counselling in prison settings. In individual meetings with inmate's health issues, risk behaviour and risk of drug use are discussed. Important feature is that as an 'outside' organisation they secure independence and trust. Evaluation reveals that there is: 1. a high level of acceptance among inmates, prison staff and administration; 2. the activity enhances ongoing contact after release; 3. their work is perceived as a valuable addition in the social support structure for drug users; and 4. evaluated as a cost-effective activity.

The European Peer Support Project contributed to large-scale implementation of risk reduction strategies in prisons in seven EU countries (Belgium, France, Germany, Ireland, Italy, Portugal and Spain). It is advised that training of both staff and inmates concentrate on prevention strategies i.e. risk and harm reduction & disease prevention, training and information on pre- and post-test counselling, psycho-social support, HIV counselling and on HIV / AIDS treatment and protocols (Stöver/Trautmann 1998).

[51] Greta Kimzeke, 2000

[52] Taylor, Stephan. June 1994)

III.6.4. Vaccination Programmes

Vaccination against hepatitis and tuberculosis is done in many prisons to avoid infectious diseases or re-infection. Prison seems to be an ideal setting for the four injections that are required within ten months (done this way in Scottish prisons) because prisoners can be contacted easily. Christensen (1999) found that although IDU's in prison have high risk of acquiring hepatitis B and C and transmission among prisoners was demonstrated, only 2% of the incarcerated IDU's (N=140) were vaccinated against HBV.

It is of great difference whether there is a pro-active way of offering the vaccination or if it is a medical service 'on demand'. Trabut (2000, 31) states for France that hepatitis B vaccination is available in all prisons, but not many prisoners know this and ask for it. There may be differences in the way how pro-actively Hep. B vaccination is recommended according to the screening results. The Advisory Council on the Misuse of Drugs (1996, 105) therefore stated "We recognise the difficulties that are involved in getting prisoners to come forward for vaccination against Hepatitis B, but recommend that enhanced efforts are made to encourage prisoners to take up this provision".

Post-exposure prophylaxis for HIV is recommended for health care workers occupationally exposed to HIV under certain circumstances (needle stick injuries). Limited data suggest that such prophylaxis may considerably reduce the chance of becoming infected with HIV[53]. The risk of acquiring HIV infection following occupational exposure to HIV infected blood is low. "Epidemiological studies have indicated that the average risk for HIV transmission after percutaneous exposure to HIV infected blood in health care settings is bout 3 per 1,000 injuries. After a mucocutaneous exposure the risk is estimated at less than 1 in 1,000. It has been considered that there is no risk of HIV transmission where intact skin is exposed to HIV infected blood (UK Health Departments 2000). Only few guidance does exist for handling PEP (except UK Health Departments 2000). It is unclear to which extent PEP is available in the medical units of the prison.

III.6.5. Provision of disinfectants

Disinfectants as well as condoms are key components in public HIV prevention campaigns. In prisons they turned out as a form of harm minimisation which on the one hand copes with the reality that syringes are existing in prison but on the other hand don't want to provide sterile new injection equipment. This practice is not very widespread.

The use of bleach for cleaning of injecting equipment is an effective tool for preventing transmission of HIV and other blood-borne diseases. The method used for cleaning is simple and effective[54], when it is done properly. The common availability of bleach for household purposes gives intravenous drug users the opportunity to take preventive measures in a rather discrete manner.

According to the World Health Organization's network on HIV/AIDS in prison, 16 of 52 prison systems surveyed made bleach available to prisoners as early as 1991. Bleach was available in some prison systems in Germany, France, and Australia, in prisons in Spain, Switzerland, Belgium, Luxembourg, and the Netherlands, and in some African and at least one Central American prison system.

One of the first bleach programmes in prison was started by an officer in an Irish prison, confronted with a strict political reality, in which pragmatic preventive health or HIV prevention was prohibited. The officer

[53] Cardo et al. 1997

[54] Reynolds A. comments on the UNAIDS brochure 'Protect Your Self', 1997.

saw to it that each toilet in his institute contained a bottle of bleach and trained the dependent inmates on proper cleaning techniques and safer behaviour.

HIV/AIDS education and instructions on the proper use of bleach provided by inmates acting as Peer educators have shown that inmates increase their knowledge and awareness of HIV/AIDS issues including the necessity of using bleach when cleaning syringes tattooing and piercing equipment. Inmates will use bleach as a harm reduction measure when provided to them in conjunction with peer and staff education[55].

Only in a few countries national recommendations do exist regarding the provision and use of disinfectants. Laporte 1997 found in his survey 10 prison systems (in total about 132 000 inmates in 1996; 23 systems in 20 countries responded) where disinfectant is available with instructions on cleaning injecting material (full strength liquid bleach in 3 cases, diluted liquid bleach in 2 cases, both in one case, bleach in powder form in one case and other disinfectants in 3 cases, which is all in all a progress to a similar study 4 years before.

Already in 1994 the Ministry of Justice of Austria (Bundesministerium für Gesundheit 1994) recommended to all prisons practically proven measures to prevent the transmission of infectious diseases. Beside face-to-face information, condom availability, the provision of disinfectants were seen as important and successful strategy to combat the spread of HIV. This recommendation clearly points out that even a disinfection done very thoroughly does not provide absolute protection. It is strongly recommended not to use 'Natriumhypochlorit' (NaHClO) because of it's chemical instability, and alcohol disinfectants may be misused by prisoners so jodophore disinfectants are handed out to drug users with the relevant information already in the admission phase. From a Swiss prison (Pöschwies/Regensdorf, Bolli 2001) we know that a refilling of disinfectant bottles by i.v. drug users is rarely done. Mostly it is refilled by prisoners with injuries or skin diseases. Similar experiences have been made by a pilot project in the prisons of Hamburg/Germany: Prisoners didn't want to refill the bottles because then they identified themselves as drug user. In Scotland sterilising tablets are handed out to prisoners with concrete instructions how to use them for sterilising mugs, cutlery, razors, chamber pots and injecting equipment (Scottish Prison Service w.y).

Branigan/Hillsdon/Wellings (2000) studied the feasibility of making available disinfectant tablets for the purpose of cleaning injecting equipment in 11 prisons in England and Wales (proposed by HM Prison Service Health Care Directorate). The 11 pilot prisons were representative of all prison types, across the estate, representing 8.5% of the total prison population in England and Wales. Four broad distribution strategies were revealed with consequent advantages and disadvantages present for each strategy. Tablets were employed by prisoners for a variety of purposes, mostly related to hygiene. Both inmates and staff reported that tablets were being used for cleaning drug injecting equipment. However, fears of widespread misuse of tablets by prisoners were not realised and there was no backlash from the media or wider interest groups concerning the intervention. The authors support the provision of disinfectant tablets, which should be introduced across the estate.

The selected distribution strategy should be harmonious with the unique characteristics of each prison's features, but should be underpinned by a set of national principles for implementation. The process should be explicitly and clearly linked to the wider framework of reducing the demand and supply for illegal drugs.

[55] Nichol TL, 1996.

In Denmark between 1996 and May 2000 prisoners could get hold of disinfectants from big bottles of bleach in the toilettes. Due to the fact that prisoners used it for other purposes than for disinfection the mode changed so that little bottles can only be received either in the medical department or in the toilets.

Bleach/sterilising tablets are distributed in all Scottish prisons since 1993 together with an information leaflet with practical instructions on how to use it to clean syringes. In most of the EU Member States, bleach is either not available or is displayed for cleaning purposes but not distributed officially and without any information campaigns on how to use bleach in order to sterilise syringes in a proper way.

In Spain every prisoner gets a coli (kit) with different hygienic products for the toilette including a bottle with ‘lessive‘ and all the drug user get instruction and brochures about the procedure of cleaning injection equipment. Every three months they get another bottle, but also in between it is possible to by cheaply in the prison shop.

From a prevention point of view bleach is the ‘next-best-solution’ only when no other safer options are available. Sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes. Furthermore the probability of effective decontamination is decreased further in prison. Because injecting is an illicit activity, prisoners can be accosted at any moment by prison staff, injecting and cleaning is a hurried affair. Studies have shown that bleach disinfection takes more time than most prisoners can take (Canadian HIV/AIDS Legal Network 1999).

Table 8: Provision of bleach in some EU countries

Country	Distribution of bleach	Substance, kits used	Access	Remarks
Austria		Betaisodonna (Jodum)	Medical Department	In 26 out of 29
Belgium				
Denmark		Natriumhypochlorit	Direct access preferably in bathrooms or toilets. Medical departments only if distribution in bathrooms etc is not possible because of sabotage.	
Finland		Potassiumper-Sulphate	Individual kit given to every incoming prisoner, freely available in washing rooms and from health care unit	
France		1 small bottle of 120ml at 12° for every prisoner every 15 days	by penitentiary dministration	(D. Khodja 2001)
Germany				
Luxembourg				not available (Reuland/Schlink 2000)
The Netherlands				Due to guidelines, bleach should be available in every prison
Portugal				In 39 out of 53. Bleach is distributed when prisoner enters prison, continues to be regularly distributed according to the criteria of each prison
Spain		**la lessive**		

Few Prisons: **Most Prisons:** **All Prisons:** **No Prisons:**

III.6.6. Needle exchange programmes

In view of the increasing number of HIV and hepatitis infections in prisons, injection drug use of men and women in detention is given increasingly more attention. This resulted in changes in the fields of order policy, health-care policy and in detention practices.

Due to the damaging effects of drug consumption in prison, which bears great risks of infection, the number of those who demand that a health care policy minimising risks for inmates is given priority over correctional concerns, constantly rises. Although preventive measures taken to avoid the spreading of infectious diseases in prisons which are not aimed at a total renunciation of drugs, are not compulsory to date, a lot of methadone programmes have already been conducted in prisons. There are pilot projects, e.g. in Switzerland, under which addicts are provided with original substances (Kaufmann/Dobler-Mikola/Uchtenhagen 2000). Similarly, innovative pilot projects under which clean drug injection equipment is made available in prisons have already been launched as trial projects in Switzerland, Germany and Spain. Currently in 19 prisons this measure is carried out (see table 11). It is hoped that they will help to raise general acceptance and efficiency of preventive measures. The scientific results of the evaluations are encouraging (see below).

Needle exchange programmes, which are an efficient and well implemented component in the prevention strategy outside prison in EU Member states to a varying degree, are not implemented inside prison walls in most of the EU-countries (except Germany and Spain).

Some countries do not have an official statement against needle-exchange facilities, whilst others explicitly reject this option, i.e. Scotland: “After careful consideration, needle and syringe exchanges are considered to remain inappropriate within the prison context. Sterilising tablets and information on their use will be made freely available for general hygiene purposes and for cleaning illegally held works”. (SPS 2000, 34).

Already in 1991 on the basis of a study on practice and policy of the provision of sterile syringes for drug users in the European Union (Stöver/Schuller 1992, 101ff) the World Health Organisation/Regional Office for Europe elaborated recommendations of HIV/AIDS prevention for drug users in prisons. The following graded measures should be realised:

- measures to reduce the number of i.v. drug users
- measures to prevent drug use
- information about the risks of intravenous routes of administration
- information about the risks of sharing used needles
- demonstration of disinfecting techniques, provision of disinfectants and means for a hygienic drug use (alcohol swabs, plaster)
- provision of sterile syringes.

In the last resort the provision of sterile injection equipment should be the strategy of choice in the HIV/AIDS – prevention. Two years later the WHO guidelines on HIV/AIDS in prison (WHO 1993) stressed the principle of equivalence: “...in countries where clean syringes and needles are made available to injecting drug users in the community, considerations should be given to providing clean injecting equipment during detention and on release to prisoners who request this” (see also chapter 2.2.2.).

Two Pilot Projects in a Women's Prison and a Men's Prison Germany

As an example of the development and implementation of the first two pilot schemes in Germany are presented in the following. In autumn 1995, the Minister of Justice of Lower Saxony (northern state in Germany) gave green light to the implementation of a two-year pilot project for the distribution of sterile injection equipment and provision of communicative methods of prevention to drug addicted inmates in a women's prison with 170 inmates in Vechta and a men's prison with 230 inmates in Lingen 1 Dept. Groß-Hesepe. Positive experiences in Swiss prisons and supporting recommendations of a panel of experts were the basis for this decision.

The pilot project in Vechta had started on 15 April 1996, using five dispensing machines which allow a needle exchange to guarantee an anonymous access. The project in the men's prison started on 15 July 1996. Here the staff of the drug counselling service and of the health care unit hand out sterile syringes to inmates. The scientific evaluation has been carried out by the *Carl von Ossietzky University* in Oldenburg, which is focussing on the aim, to assess the feasibility, usefulness and efficacy of the measures undertaken, beyond the various interests of the persons and institutions involved. Of special interest is, whether and how changes occur:

- in the prison system itself (acceptance of the measures by staff, medical service and management, changes in the perception of addicted prisoners, credibility of the preventive measures according to the spread of infectious diseases, security matters).
- in the drug user's behaviour (needle sharing), knowledge (risks of intravenous drug use, 'safer-use', 'safer-sex') and assessment of the pilot project. Changes in the health status of the prisoners will be examined anonymously in combination with the results of the medical evaluation.

Table 9: **Synopsis Needle Exchange in two German Prisons**

	Women's prison Vechta	**Men's prison Lingen I Dept. Groß-Hesepe**
Average number of inmates	183	267
Forms of sentences	All forms of sentences: juvenile/ adult delinquency/ custody/ remand pending, deportation	Only adult sentences
Percentage of (former) drug users	About 50%	About 50%
Start of project: End:	15.04.96 14.04.98 continued	15.07.96 14.07.98 continued
Mode of distribution of sterile syringes and needles	5 needle – exchange slot machines discreetly located in different wards	Hand to hand distribution by the internal drug counselling service
Goals	- Prevention of the spread of infectious diseases - Health Promotion - Easy, anonymous accessibility in order to abolish the status of syringes as goods - Protection of the personnel	- Prevention of the spread of infectious diseases - Health Promotion - Easy, anonymous accessibility in order to abolish the status of syringes as goods - To get into personal contact with more unknown drug users

	Women's prison Vechta	Men's prison Lingen I Dept. Groß-Hesepe
		- Protection of the personnel
Access to the programme	By declaration of drug addiction to the doctor/given out a dummy Registration once	By declaration of drug addiction to the doctor/drug counselling service/given out a syringe
Exclusion	Drug users being in methadone treatment (about 40), prisoners in the entrance department	Drug users being in methadone treatment (about 20)
Practice	- Access to one or more of the 5 automates	- Access to the rooms of the Drug counselling service and contact café - Registration of needle exchange and the frequency of exchange
Storage of the syringe/needle	Visible in a plastic container on the washbasin console	In the cupboard in a special holder
Number of participants in the pilot project ever	169	83
Number of exchanged needles Daily:	16,390 23	4,517 6
Percentage of returned syringes	98.9% 167* missing *(16.08.96-14.04.98)	98,3% 76 missing
Additional preventive information/education units	by JES (Junkies, Ex-User, Substitutees) and local AIDS-Self-Help group for inmates,	- by local AIDS-Self-Help group - by project staff to colleagues

Implementation of the Pilot Projects

Women's prison Vechta

As part of the admission procedure at the beginning of incarceration every inmate is informed in good time by means of a multilingual information paper about the modalities of a participation in the needle exchange project. Further pertinent information (safer use, safer sex) is given in the admission unit by experts on support for addicts. Needles can be exchanged in all sections of the prison, however not in the "leave" section, in the home for mothers and children and in the admission unit. The dummy of a syringe which must be inserted into the machine in order to obtain a sterile syringe is only handed out to drug-addicted inmates who have been examined by the prison doctor and whose addiction has been documented in their medical record. Inmates participating in a methadone programme are excluded from the needle exchange because they contracted for renouncing any additional consumption of drugs.

Minors require their parents declaration of consent. The machines were set up in four easily accessible places in the prisons. The dummy can be exchanged for a functioning syringe and after use can be exchanged for another sterile one. The machines also contain heat-sealed alcohol swabs and ascorbic acid in adequate portions, filters, plaster and ampoules holding a sodium chloride solution. The machines are emptied and refilled daily and by trained staff of the health care unit.

The information meetings for inmates complementing the exchange of syringes are designed to provide extensive information about the risks involved in injection drug use, to reduce health-damaging forms of consumption and to practise safer use techniques for the time after imprisonment. The drug-addicts are also educated about behavioural patterns that are in agreement with the goals of the project: they should only have a syringe on them when it needs to be exchanged, prohibition of lending or selling syringes,

each inmate may only possess one syringe, the syringe must remain in the prison if the inmate is transferred to another prison. Moreover a "safer sex" and "safer use" training is offered once a week to all interested inmates.

At the beginning of the project the prison staff was given the opportunity to participate in a one-day information seminar. In addition to this, special information meetings are offered which the staff may attend during working hours in order to keep them informed about the latest in first aid, prophylaxis of infections, pharmacology and the handling of drug-addicts. Possession of drugs is still prosecuted. Therefore the project cannot be considered a liberalisation of drug consumption in detention but must be viewed as a dealing with the reality of drug consumption in prison.

Owing to the legal frame of the model project it seems unlikely that increased controls of cells or extended urine controls will be conducted.

Men's Prison in Lingen I, Dept. at Groß-Hesepe
After extensive discussions of the concept underlying the health-promoting project, of basic questions and of its implications for detention, the exchange of syringes started on 15 July 1996.

Contrary to the method applied in Vechta, no machines were set up in the prison of Groß Hesepe. Here the staff of the drug counselling service and of the health care unit of the prison hand out sterile syringes to inmates producing used ones during fixed hours (daily) in a tea-room. The tea room is located next to the drug counselling service and it is difficult to see into it. The inmates can reach it via the recreational ground. Prisoners intending to exchange syringes in the tea-room may spontaneously use the opportunity to also obtain counselling if they wish to do so. The participants in the exchange project have been assured that the provision of syringes is anonymous. The staff handing out the syringes have the duty to maintain confidentiality. All drug-addicted inmates may participate in the project. Prisoners participating in a methadone programme may not participate in the needle exchange project because they have contracted for renouncing any additional consumption of drugs.

In addition to the exchange of syringes further support services will be offered:

- individual counselling on HIV/AIDS provided by the staff of the health care unit and of the drug counselling service and the regional AIDS support group;
- handing out of multilingual information papers on HIV/AIDS, safer sex and safer use;
- information meetings on HIV/AIDS and hepatitis;

Support measures like training courses on First Aid will also be offered for the prison staff to brush up and deepen already existing knowledge. Information meetings will be organised at irregular intervals by the drug counselling service and the AIDS support group.

Extensive discussions prior to the implementation of the project which were designed to render the project transparent, helped staff to develop a great deal of sensitivity for the drug problem and its medical and psycho-social implications. Thus a solid basis and the acceptance required for a successful realisation of the project was created.
The great readiness of the prison staff to actively participate in the project was also reflected in the great number of staff who co-operated with the scientists involved in compiling the first data.

The scientific evaluation recommended to not only continue these two pilot projects but expand them to all of the prisons in Lower-Saxony under specific conditions. The Ministry of Justice of Lower Saxony

supports such an expansion but not as a top down decision against the resistance of the staff in these prisons. The two pilot projects are both carried on. Meanwhile in Berlin (two prisons) and Hamburg (three prisons) needle exchange schemes have been successfully introduced. Other states are discussing to implement them in prisons. After a successful implementation of needle exchange programme in Basauri all penitentiary centres were recommended the start-up of this preventive activity by the Penitentiary Institutions (see Table 11).

Needles and syringe exchange in the Bilbao prison.

In August 1997 a pilot programme for the exchange of syringes was started in the Bilbao penitentiary (Basauri), as an alternative for certain drug addicts who were active consumers but would not accept inclusion in treatment with methadone. In November 1998, another programme of similar characteristics was implemented in the Pamplona penitentiary centre.

Characteristics of the Plan for the Exchange of Syringes implemented in Basauri:

- Constitution of a Committee for following up the programme, formed by representatives of the Departments of Justice and Health of the Basque Government, the Ministry of Health and the Penitentiary Institutions.
- Execution of informative and training actions, with different contents, aimed at prisoners and penitentiary personnel.
- Exposition of the project to the Treasury, the Penitentiary Surveillance Court and the Basque Parliament.
- Modification of the regulations on the internal regime which considered syringes to be unauthorised objects. The possession of syringes is permitted within the conditions of the programme.
- The supply/exchange of syringes is carried out by means of human resources.

Drug testing

Urine analyses are performed on the prisoners to observe the progress in their treatment. These are performed either by a legal order or in the penitentiary centres. The high percentage of negative analyses must be emphasised and the substance most detected in the positive analyses is cannabis.

Drug dependence is considered as a risk variable for violating permits.

Statistics

During 1998, 481 drug dependent injected interns have been included. 4,050 syringes exchanges have been made.

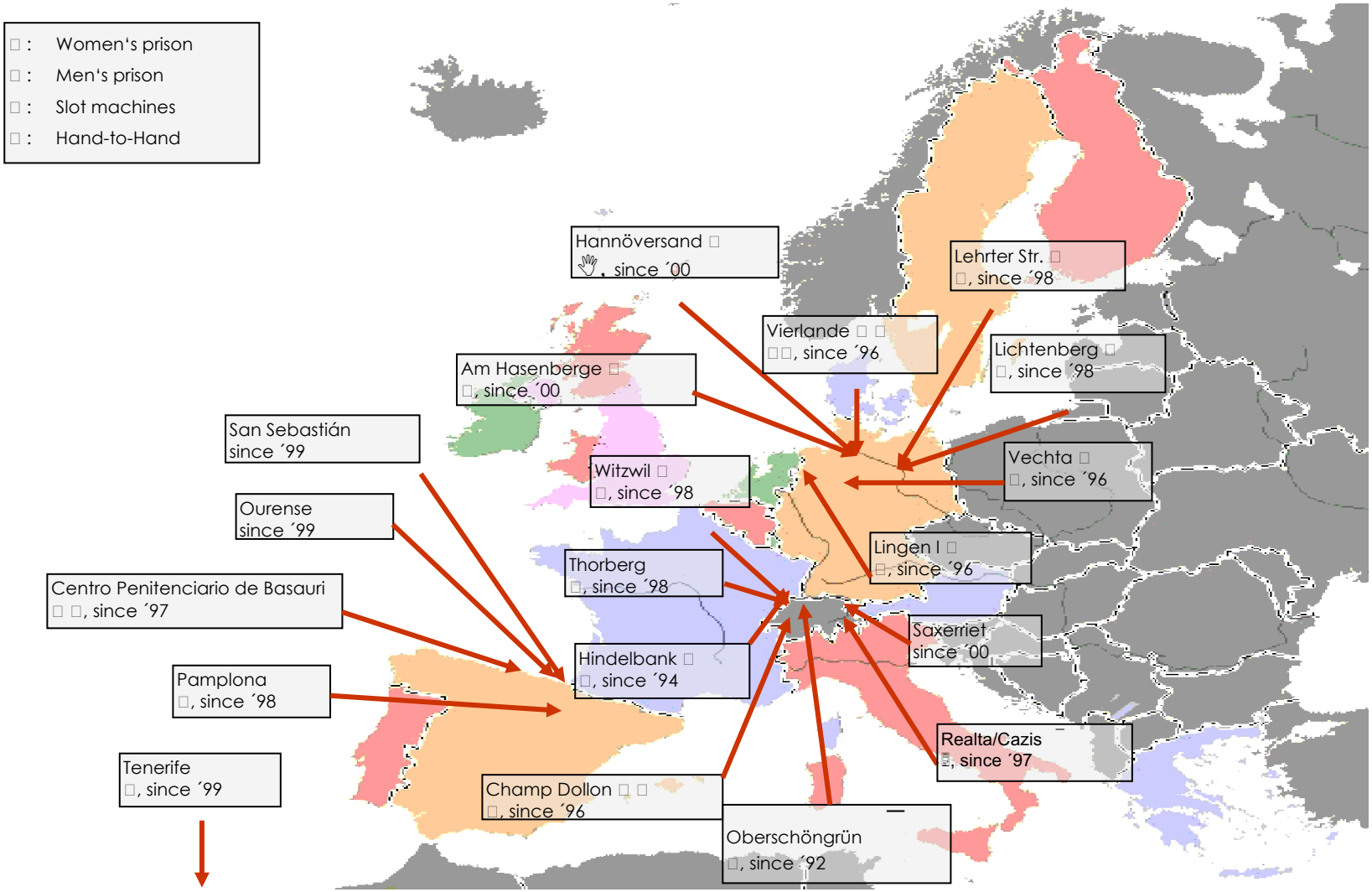
Summary

In view of the success of the pilot projects installed they are copied relatively slowly due to the resistance of the staff members, politicians, trade unions and their political lobby. Parallel in Switzerland only four of such projects have been started until now. Syringe exchange schemes are still a big political issue because they seem to symbolise the failure of keeping prisons drug free. But more and more harm-reduction measures are being introduced in prison health care in order to prevent drug related damages. The Needle Exchange Projects described in table 11 are smaller parts of a broader goal and embedded in a comprehensive prison drug strategy.

Table 10: **Needle Exchange Programmes (NEP) in EU and Swiss prisons (chronologically)**

Prison:	Site	Size	Character	Sentenced	NEP since /evaluated?	Provision of sterile syr.	Exclusion
Men's prison Oberschöngrün	Solothurn, Switzerland	75	Half-open	Adults	1992	Doctor/Medical Department	Non-DU
Women's prison Hindelbank	Bern, Switzerland	110	Closed	Adults	1994/yes	Slot machines (1:1- Exchange)	No
Men's & Women's prison Champ Dollon	Geneva, Switzerland	No details	Remand Prison	Adults	1996	Doctor	No
Women's Prison Vechta	Vechta, Germany	169	Closed & Remand Dep.	Adults/ Juveniles	1996/yes	Slot machines (1:1- Exchange)	Women in Methadone Programme, Reception Dep., Non-DU
Men's Prison Lingen I Abt. Groß Hesepe	Groß Hesepe, Germany	228	Closed	Adults	1996/yes	Hand-to-Hand Drug Counselling Service	Men in Methadon-Programme, Non-DU
Men's prison Vierlande (with a section for 21 women)	Hamburg, Germany	319	Open	Adults	1996/yes	Slot machines (1:1- Exchange) + Hand-to-Hand)****	No
Men's prison Centro Penitenciario de Basauri	Vizcaya Spain	250	Half-open	Adults	1997/yes	Hand-to-Hand	
Men's prison Realta/Cazis,	Graubünden, Switzerland	100	Half-open	Adults	1997/yes	Slot machines (1:1Exchange)	No
Women's prison Lichtenberg Berlin	Berlin Germany	Ca. 40-50	Closed	Adults/ Juveniles	1998/yes	Slot machines (1:1Exchange)****	No
Men's prison Lehrter Str., Berlin	Berlin, Germany	Ca. 100	Closed	Adults/ Juveniles	1998/yes	Slot machines (1:1Exchange))****	No
Pamplona	Spain				1999/yes	Hand-to-Hand Staff member	
Tenerife	Spain				1999	Hand-to-Hand Staff member	
San Sebastián	Spain				1999		
Ourense	Spain				1999		
Women's prison Hannöversand	Hamburg, Germany	46	Closed and open	Adults	Jan. 10th 2000	Hand-to-Hand	No
Men's Prison Am Hasenberge	Hamburg, Germany	494	Closed	Adults	Febr. 15th/ 2000/yes	Hand-to-Hand	Men in Methadon-Programme, Men in high security areas
Men's Prison Witzwil*	Berne, Switzerland	180	Open	Adults	1998	Hand-to-Hand	No
Thorberg	Berne, Switzerland	185	Closed	Adults	1998	Hand-to-Hand***	No
Prison Saxerriet	Salez, Switzerland				2000/yes		

Needle Exchange Schemes in EU and Swiss prisons



Notes:

Non-DU = Non-Drug Users; 1Medical department (doctor and psychologist),

* in the canton of Bern/Switzerland needle exchange has been introduced by an official instruction

** special consultation hour

*** rarely used

**** in these cases the first syringe is handed out by external agencies (drug or AIDS services). In all other cases the first syringe is given out by either the doctor, medical service, social worker or internal prevention team.

There is no general recipe for the mode of needle exchange programmes: Every prison system has to find it's own way of distribution. The different modes of are related to the goal the prison is pursuing: whether the prison is interested in getting more contact to formerly unknown user (via personal contact in hand-to-hand provision, in men's prison in Lingen, Spanish projects, Carrón 2000) or if the contact is already satisfactory and the only reason is the provision of clean injection equipment via slot machines (for instance women's prisons Vechta/Germany and Hindelbank/Switzerland). Both modes do have advantages and disadvantages in terms of guarantee or lack of anonymity. It is of interest from whom prisoners receive the first syringe, because of a guarantee of anonymity, for which inmates require to a high degree.

In Switzerland the positive results of the evaluation studies have resulted in the Ministry of Justice releasing an official statement confirming the legality and the 'necessity' of such programmes and one canton (Bern) now requires needle exchange schemes in all prisons.

III.7.Community Links

The past decade has seen substantial growth in both the development of approaches to divert individuals away from prison and into treatment alternatives and in the development of a range of services within prisons.

Specific legislation in a number of countries has attempted to enhance links between the criminal- justice and health services in order to reduce the number of drug users entering prison. Despite this development, the size of the addicted population in prisons has grown. This development emphasises the need for better links between criminal-justice agencies and drug services.

In many countries drug laws are adapted to the provisions of the 1988 UN Convention. The legislation punishes trafficking, production, possession and in some countries also the act of consumption. The penalties vary according to the national legislation, one of the penalties may also be imprisonment. The principle 'therapy instead of punishment' is adopted in most European countries, that means, if the accused has or expects a sentence up to a certain period of time (i.e. Germany up to two years) and he/she agrees to voluntary treatment, the court may suspend the sentence and the accused will go into an in-patient treatment centre (therapeutic community) or into ambulatory centres which are slowly but surely accepted as treatment options. In some countries this chance is also offered to prisoners with times of imprisonment left.

III.7.1. Pre-Release units and release

On the 12th Conference of Directors of Prison Administration (26-28 November 1997 in Strasbourg) it has been clearly stated that “the preparation of prisoners for release must begin on the day the sentence starts and should be part of the sentence planning process. All staff should be involved in preparing prisoners for release” (Council of Europe 1998). The time of release is perceived also as a crucial time for drug using prisoners. The risks of relapse and following overdose are extremely high (see chapter 2.3.2.). To avoid these risks therefore in several countries pre-release units inside prisons have been established in which drug dependent prisoners live who are going to be released in the near future. In France in 7 prisons these units have been established in order to offer drug using prisoners who have been transferred there on a volunteer basis a four-week course of group treatment (10 persons) with the aim of preparing them for release (Trabut 2000, 23)

The preparation of release is done differently in the 15 EU-countries. Beside basic social and health aims is one of the central aims to continue the support after release. It is clear that the challenge for prison services in order to facilitate a successful return to the community, often involves not only treating a drug problem, but often also needs to include addressing offending behaviour, employability, education deficits and maintaining family ties. The effects of this work can best be seen in the release phase.

In the Austrian prison 'Vienna Favoriten' there was an intensive support in the months preceding release, this is an additional and intensive programme to the normal pr-release measures. But although the evaluation showed that the goal of continuity of support could only be reached in 10% of the cases, the clientele judged the offer as helpful and important to prepare for outside (see EDDRA data base of EMCDDA; Österreichisches Bundesinstitut für Gesundheitswesen 1999, 40f).

In France for instance in most of the penal institutions there are groups of up to ten inmates who collectively are prepared for their release during 4 weeks. The developed training modules contain elements like raising of general responsibility, examination of social and health status. External partner are integrated in achieving individual help plans after detention[56].

Again at the situation of release, the problem is to integrate harm reduction information in case of a relapse to heroin or polyvalent drug use after leaving the prison. Only a few prison speak pro-actively of the case of relapse (i.e. brochure of the Scottish Prison Service). Also in the prison of Antwerp a brochure is available for those who leave the prison. It specifically focuses on practical information, health and risk problems (i.e. overdose) at the moment of release. This brochure is also made by an external service.

The overall objective of this chapter is to identify measures that are taken in prison in order to prepare drug using prisoners for release:

- measures to achieve/maintain a drug free status after release
- can home leave and conditional release be granted and are they integrated into treatment processes?
- Co-operation with outside drug services or doctors into the planning of a prisoner’s release
- involvement of self-help groups into the release phase

[56] An evaluation of these measures aiming at preparation of release is underway

- effective measures taken in prison to prevent that prisoners die of a drug overdose shortly after release?.

Most of the examined countries undertake big efforts to reduce relapse and to provide social reintegration. Therefore sometimes protocols are set up with drug treatment centres from the national and community health networks. In Portugal i.e. there are projects like 'To prepare for freedom' and 'To have a life to have a job. Moreover peer groups are developed to support treated drug addicts as a measure to prevent relapse.

In Spain drug dependent people who have been under treatment during their stay in prison are able to continue therapeutic care when they are finally, conditionally or provisionally freed. During 1998, 7,180 interns have been transfered to community programmes (40.7% more than in 1997).

In Denmark a treatment plan should be drawn up for each inmate and co-ordination between the prison and the social authorities about the work done for an inmate when planning release and aftercare should be ensured. Official guidelines have drawn up by a working group with representatives from the Ministry of Social Affairs and the Department of Prison and Probation. These guidelines- *Vejiedende retningslinier for samarbejdet mellem de sociale myndigheder og Kriminalforsorgen,-* are addressed to the social authorities as well as to the Probation service all over the country and describe how the co-operation between the various authorities should take place.

III.7.2. Aftercare

In May 2000 Cranstoun Drug Services (Fox 2000) embarked on a research project to survey aftercare programmes for drug-using prisoners in several European countries. The main purpose was to gain an overview of different approaches to the problems of post-release recidivism and relapse and to highlight examples of good practice in aftercare. Study visits in Austria, Sweden, and Scotland were carried out. Further visits are planned. Results are quoted here:

In Scotland, the need for co-ordinated throughcare is glaringly apparent. In Glasgow's Barlinnie prison, 28% of prisoners surveyed had been to prison more than fifteen times. The average number of releases among prisoners was 9. Prison administrators say that these men are "serving a life sentence in instalments". 60% of prisoners said they were addicted to drugs before coming into prison. Over 10% predicted that, without in-prison help to overcome their addiction, they would die after release. Barlinnie is building up in-prison services for drug-addicted prisoners. A new addictions unit is planned for later this year. Prison administrators admit that providing co-ordinated aftercare is a harder task. While many addicts are now receiving help in prison, a large proportion still feel that their eventual return to prison is inevitable due to the lack of prospects on the outside and the lack of accessible post-release support.

Austria and Sweden have a far more integrated system of aftercare than is found in the UK. For starters, the option for treatment and rehabilitation rather than incarceration (similar to the UK's new Drug Treatment and Testing Orders) has been part of their Criminal Codes for many years. So, compared to the UK, fewer short-sentence prisoners enter the penal system. Aftercare in Sweden and Austria is largely built in to the sentence plan. In Austria, prisoners serving their sentence at 'Favoriten', a prison dedicated to those with drug- or alcohol-related problems, are released in stages during which they are allowed furloughs of increasing duration and are required to find paid work. Theoretically, by the time they

are permanently released, they should have overcome their addictions and successfully re-integrated into society.

In Sweden there is a legal framework that allows a prisoner to apply for serving his sentence in a rehabilitation facility. Under certain circumstances and conditions this can be granted. The use of this possibility has however declined in recent years. In the year 1999 532 inmates were transferred to such facilities, which represents a decline with almost 30% compared with the situation in 1994. The prison and probation service and social services co-ordinate, to facilitate and finance these arrangements. The Swedes have adopted a novel approach to the problem of scarce aftercare resources: the government within the general welfare system gives financial incentives to employers and families to take on prisoners during the last portion of their sentence or after release. Some prisoners opt to live with a 'foster family' for up to a year. Such placements are usually in rural areas where the prisoner can concentrate on overcoming his addiction in a safe, supportive and drug-free environment. In a country that has an unemployment rate below 5%, great emphasis is placed on job training and placements.

Release does not have to mean inevitable relapse and recidivism. By pooling knowledge and ideas from around Europe, we hope to chart a brighter future for Britain's prisoners.

Fox (2000, 7) comes in her four country study to the following conclusions:

- "Aftercare for drug using prisoners significantly decreases recidivism and relapse rates, and saves lives.
- Inter-agency co-operation is essential for effective aftercare. Prisons, probation services, drug treatment agencies, health, employment and social welfare services must join to put the varied needs of the drug-using offender first.
- Drug treatment workers must have access to prisoners during their sentence in order to encourage participation in treatment and plan release.
- Short-sentence prisoners are worst placed to receive aftercare and most likely to re-offend. These prisoners need to be 'fast-tracked' into release planning and encouraged into treatment.
- Ex-offenders need choice in aftercare. There is no 'one-size-fits-all' in drug treatment
- Aftercare that is built-in to the last portion of a sentence appears to increase motivation and uptake.
- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend."

Several studies show that effective after-care for drug using prisoners is essential to maintain gains made in prison-based treatment. Despite this widely acknowledged fact prisoners often have difficulties in accessing assessments and payment for treatment on release under community care arrangements, as Costall (1999) stated in his study for the London region.

III.7.3. Working with families and maintaining family ties

The European Health Committee stated in 1995[57]: "One of the inevitable consequences of imprisonment is the temporary weakening of social contacts. It is true that family ties are not broken off completely, in the sense that in most cases a visit of at least one hour per week is permitted, nevertheless the prisoners' relationships suffer enormously from the confinement. A large number of wives, husbands and children of

[57] in the final report 'The Organisation of Health Care Services'

detainees feel punished themselves to a similar extent as their convicted spouses and fathers. Besides, and worse still, in many cases the marriage is bound to fail or be ruined. Social contacts in general are also suffering as a consequence of the imprisonment. In some countries like Denmark and Switzerland prisoners, are given the opportunity to receive their partners without supervision. Also in Sweden supervision is fairly relaxed".

Working with families of prisoners is a central part of rehabilitation and social reintegration in many countries. In some (i.e. Scotland) special 'Family Contact Development Officers' (FCDO) are employed to help families to keep or initiate contact with prisoner's relatives, to help to work on relatives' drug problems, to inform families about drug problems in prison and outside, to enhance family visits etc.

III.7.4. Through care

In some countries through care is perceived as the crucial factor in the success of tackling drug use in prison. The English/Welsh 'Prison Service Drug Strategy' gives a definition: "By through care we mean the quality of care delivered to the offender from initial reception through to preparation for release establishing a smooth transition to community care after release.". According to that definition there should be in practice direct links with sentence management or with incentives and earned privileges schemes.

Through care is similarly seen by the Scottish Prison Service (2000, 43). The following aims are described:

- To understand the pressures and fears affecting peoples judgement on entry to prison
- To ease the transition process between community and prison for drug misusers
- To provide continuity, as far as possible, for those receiving treatment and support in the community on arrival in prison, on transfer between prisons, and on return to the community
- To recognise the opportunity that imprisonment offers to drug misusers to begin to deal with their drug misuse problem, particularly for those with no experience of community helping agencies
- To ensure that drug misusers have the opportunity of leaving prison in a better physical state, with a less chaotic lifestyle, than when they entered
- To minimise the dangers of reduced tolerance levels on release from prison.

This comprehensive approach often affords a specific plan for the individual, designing next steps to achieve and to control and probably adjust this plan from time to time. Outside helping agencies have to be integrated into that plan. Furthermore, through care if it is seen independently from accompanying staff, planning seems to be realised only in some establishments to a certain extent. As drug using inmates are serving often short-term sentences, these plans are not realised. But a sentence plan offers the chance to support more basic requirements (such as housing, work facilities, family relationships etc.), the offenders' needs have to be identified and incorporated. Finally inmates are often brought from one prison scheme to another and efforts of through care have to be made in order to continue treatment or social or health promoting efforts. The Scottish Prison service formulates some general considerations that are necessary requirements for through care:

- good working relationships and clear lines of communication between prisons and external service agencies

- a partnership approach should be used best from drugs workers in prison with their clients in which different competencies are co-ordinated
- encouraging of contacts of agency and inmate
- continuity of care should be maintained where possible particularly for short-term prisoners.

Through care must be seen as multi-agency co-operation, which means an intensive integration of outside agencies, which at the time of release are to continue these efforts. The point of release is perceived as vital: how to continue the treatment work done in prison and have these been adjusted to those outside while in prison? The phase of preparation for release should intensively integrate outside steps as well as community based professional drug workers. After release probation officers are involved in further treatment. In some countries (i.e. Germany) the systems of prison and probation are not linked with each other so that treatment and support seems to be starting from a new point.

In Sweden prisoners as a rule are allocated to a contact person from the basic prison staff, who has a comprehensive task to fulfil:

- to give information
- after an inquiry prepare a treatment plan,
- prepare the meetings concerning the prisoner in the prison Treatment Board
- plan and make preparations concerning leaves as well as to
- support the prisoner in preparatory work for his release (Krantz/Ekström 2000).

So this is some form of personal throughcare, that one officer is responsible for the prisoners needs during the whole sentence.

The term ‘throughcare’ is also differently used in the sense of a throughcare of control agencies, i.e. Scotland: “Appropriate arrangements will be made with police and other criminal justice agencies to ensure that those involved in the supply of drugs are monitored appropriately as they move through custody, from admission to prison, through transfer between establishments, and on to release to the community” (Scottish Prison Service 2000, 25).

III.7.5. Therapeutic Communities for sentenced offender outside prison

Several countries do have legal regulations to suspend the sentence for drug users or in a more general way, if the alternative is serving to assist their subsequent adjustment in the community. In Sweden Section 34 of the Prison Treatment Act states that a prisoner may be permitted – while still serving his prison sentence – to be placed on a treatment facility outside prison. This is not by definition a suspended sentence – it is an alternative to stay in prison all the time until release. Another possibility is that the court sentences a person to Probation with Contract Treatment. This is possible when there is a clear connection between drug abuse and criminality. The person has to accept and give his consent to treatment instead of prison. If the person interrupts or neglects the treatment the Contract Treatment should be interrupted and converted to a prison sentence (Krantz/Ekström 2000).

Alternatives are mostly directed to a certain length of sentence, for example in Germany Section 35 of the Opium Law allows prisoners to undergo 'treatment instead of punishment' when the sentence to serve is not longer than 2 years. In Greece after a period of seven to ten months in custody a drug user may apply

to the Public Prosecutor to continue treatment outside prison, using a law specifically designed to allow drug users to receive therapeutic treatment rather than to stay in prison (Marinopoulou/Tsiboukly 2000, contribution to penlex Drugs, Prisons, and Treatment).

Counselling and community health structures

Counselling is a direct, personalised, and client-centred intervention designed to help initiate behaviour change to keep off drugs, avoid infection or, if already infected, to prevent transmission to other inmates or partners, and to obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy.

Medical staff requires different information than guards or surveillance staff; inmates have their own specific background, subculture and language. Prevention material from outside cannot simply be transferred to the prison setting; the relevant target groups require prison-adopted versions. This necessarily needs input from the different groups, based on interviews and focus-group discussions. Initial drafts and design need to be tested and approved. The WHO states that: “it is important to recognise that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information...”

Involvement and support from municipal health structures should have priority, especially non-governmental HIV/AIDS organisations have valuable expertise and networks that can contribute to enhancing quality of material development and sustaining this as an ongoing activity.

In almost all states of the Federal Republic of Germany outside drug service providers are included in taking care of inmate drug users. Some prisons even have their own advisory bureau on drug issues and in some prisons the social workers take care of these problems. Including outside workers promotes the necessary orientation towards the outside world. In contrast to inside workers, outside workers are more widely accepted and trusted by prisoners because the outsiders have a duty to maintain confidentiality and have the right to refuse to give evidence. Moreover the outside workers are more experienced and know about the content of/requirements for the various support services offered. Counsellors on drug issues in prison should primarily provide information about the various support services/programmes available inside and outside prisons. In a second step their efforts should focus on motivating prisoners to overcome their drug use. The main goal to be pursued by outside workers still is to incite drug addicts to participate in outside therapy programmes (in compliance with § 35 of the Law of Narcotics) and to prepare inmates for these therapies. The applied concept of the therapy-providing institution/ facility should be discussed with the inmate, just like the question of who bears the costs and who takes care of the prisoner during the therapy.

Many prisoners, however, were greatly scared of and had many reservations about a long-term inpatient treatment. The readiness to participate in these treatments decreases with the number of therapies already undergone (some of which included restrictive methods) and with the extent of the period of incarceration. Outpatient treatments (in compliance with § 35 of the Law of Narcotics) are still rare and most of them are not accepted by the prosecution.

It is a major advantage of outside drug counselling that it establishes a link between life inside and outside prison and thus is very helpful for continuing treatments that were started in prison beyond completion of the sentence. In this way long-term contacts can be forged, ensuring continuity.

It often depends on personal choices and function in the prison system that inside drug worker and staff of the medical unit are also well accepted by inmates. De Santis (2000) reports from her low threshold strategy of ‘streetwork’ inside prison with the objective of confidence building.

PART IV: EVALUATION OF DEMAND AND HARM REDUCTION INTERVENTIONS IN PRISONS IN THE EU

IV.1.Introduction

Prisons remain an area where there is major variation in levels of provision. There are limited evaluation data to guide policy-makers in determining the best course of action for the future. More evaluation of delivered prison treatment is needed.

The utility of qualitative research on injecting drug use is increasingly recognised, particularly in the light of the emergence of HIV, HCV and other blood-borne infections associated with drug injecting, it is evident that qualitative research on the risks associated with injecting drug use remains under-ressourced in most European countries. This finding of the 'Workgroup Review Of Qualitative Research On The Health Risks Associated With Injecting Drug Use' (2000) is applicable to the research situation in prisons. Although there remain some ethical questions, there is very little qualitative research in this field, especially a lack of longitudinal studies including short period of time after imprisonment.

Ethnography and qualitative research is concerned with descriptions of how the risks associated with injecting drug use are "lived" and interpreted through everyday interaction and experience. A prime concern of qualitative research is to explore the meanings and contexts of action rather than the charting of it. This implies gaining a deep rather than broad understanding of behaviour. Qualitative research proceeds on the assumption that it is possible to gain insight into the factors producing social behaviour primarily through engaging with the lives of actors themselves and the interpretations of their actions they give. While there are varying degrees to which this is possible or desirable (either methodologically, practically or ethically), the aims of qualitative research on the health risks associated with drug injecting are to 'discover' the context-dependent meanings and experiences of risk behaviour. In doing so, qualitative research complements the findings and interpretations proffered by deductive designs.

In addition, we conclude that qualitative methods are an essential component of intervention developments since they, unlike deductive approaches, have the capacity to describe and understand the meaning and experience of drug use and risk reduction from the perspectives of drug users themselves. In conclusion, we would like to reiterate that we see the functions of qualitative research on the risks associated with drug injecting to be five-fold:

- to provide methods capable of reaching and researching ‘hidden’ or ‘marginalised’ populations;
- to inform, as well as to question, the design and interpretation of quantitative designs and findings;
- to describe the social meanings attached to drug injecting and risk behaviours, and of risk reduction interventions, from the perspectives of participants themselves (and particularly IDUs);
- to describe the social context of drug injecting, risk behaviours, and risk reduction interventions, and the social and contextual factors (including policy) which influence risk perception, behaviour change and intervention development; and
- to describe and assess the relevance, feasibility and effectiveness of risk reduction and public health interventions targeting IDUs and their sexual partners.

IV.2. Evaluation criteria

In this sub-chapter criteria to evaluate demand and harm reduction measures are developed. Basically already existing procedures to evaluate demand reduction interventions outside will be checked to be applied and adjusted to the prison setting (e.g. EMCDDA 1998).

To get reliable and comparable data, evaluation criteria for demand and harm reduction interventions have to be developed. Overall issues in the definition of evaluation criteria are: feasibility, degree of acceptance, and efficacy of the measures undertaken, taking into account the different interests and values of the persons and institutions involved.

As regards interventions it is of particular importance to determine if changes in drug use behaviour occur; the following criteria may be used as a basis for this analysis:

- abstinence from drugs (abstention from drug-use during specified periods)
- reduction of drug use (consumption of smaller amounts)
- reduction of harmful and damaging drug use (changes in drug-using patterns, changes in drugs used, avoidance of overdoses)
- reduction of harmful and damaging drug use patterns (e.g. shift from injecting to smoking)
- improvement of risk- related knowledge ('safer-use', 'safer-sex')
- improvement of health status
- improvement of social and communicative skills and competence (e.g. participation in treatments offered, compliance with rules dominating the treatments, participation in self help groups, involvement in peer support activities).

But the prison system itself can also be the subject of an evaluation. Studying the effects of interventions, the following criteria can be applied:

- scale of acceptance of the measures by prison officers, medical staff and management,
- changes in the attitude towards drug using prisoners,
- level of credibility of the preventive measures
- impact of the measures taken on security matters,
- consequences of a participation in treatments offered for the length and quality of the sentence to be served by inmates (advantages/disadvantages, impact on family visits, home leaves etc.).

IV.3. Results of evaluations

In this sub-chapter results of already terminated evaluations of demand and harm reduction interventions in prisons in the EU are presented, like the creation and management of drug-free units in Austrian and Dutch prisons (Hurk 1998), needle exchange projects in two German prisons (Meyenberg/Stöver/Jacob/Pospeschill 1999) and several EDDRA presented projects (Österreichisches Bundesinstitut für Gesundheitswesen 1999, 41). Special attention is given to studies covering several European countries, e.g. implementation and cross- national comparative studies (cf. O'Brien/Stevens 1997; MacDonald 1999).

The conclusions drawn from these evaluations are presented and are matched against what we already know about the effectiveness of certain interventions and the areas, which require further research.

A literature survey[58] (of mostly North-American literature) on the effectiveness of the criminal sanction system, including correctional treatment in general and treatment designed for specific types of offenders (amongst others drug addicts) found out that programmes based on cognitive-behavioural principles seem to be the most effective. Some features of programmes most closely linked with success are:

- "a theoretically sound concept;
- 'programme integrity';
- competent staff, good physical conditions, structured setting;
- thorough assessment of the offender and targeting his specific criminogenic needs;
- intensive service for high risk delinquents (those who have a great risk to recidivate);
- relapse-prevention and aftercare".

The latter points have already be stressed as important prerequisites for a successful intervention and treatment in prison and stabilisation afterwards (see chapter 3.9. and 3.10).

Apart from these very general features, one of the basic questions remains which impact does the degree of voluntariness have on the outcome of intramural treatment? In most of the prisons in the European Community drug using offenders are offered a choice between participating in an intramural or even extramural treatment programme or being detained in a normal prison or remand institution. "Especially a group of 'hypercriminal' drug-addicted offenders with a long history of drug use, who have committed many crimes and who cause a lot of inconvenience, often prefer detention to treatment. This is partly explained by the fact that, due to the petty crime character of their delinquency, they will only be convicted to relatively short prison sentences" (Ministry of Justice/The Netherlands 1998, 89). In The Netherlands a new legislation makes it possible that drug-addicted offenders may be involuntary committed to an intramural treatment programme for a maximum period of two years.

The results of a literature exploration of experiences with modalities of involuntary treatment[59] show that coerced admission in a treatment programme often has a positive effect on drug use, criminality and other social behaviour of older offenders with a long-standing drug addiction. "Most importantly there seems to be evidence that coerced admission in itself does not negatively affect the outcomes of treatment." The authors explain this by the importance of the factor 'retention in the treatment programme' for the success of it. Drug-addicted offender should stay long enough in the programme to allow motivation for a change of lifestyle. "Furthermore there are indications that participation in a multi-phased intramural *and* ambulant programme with the eventual participation in a self-help group, is more effective than participation in *only* an intramural or an ambulant programme" (90).

To answer the question raised above, what is the outcome of coerced treatment in prison more studies have to be carried out and the comparability of circumstances and penal and therapeutic conditions have to be kept in mind.

[58] conducted by the Scientific and Documentation Centre of the Dutch Ministry of Justice (2000)
[59] conducted by the Scientific and Documentation Centre of the Dutch Ministry of Justice in 1998

Amongst others the following treatment programmes have been evaluated and the results will be presented here[60]:

Drug free units in Dutch Prisons: Towards and effective rehabilitating intervention?

The current tendency is to deal with the problem by increasing the number of care and treatment options. In 1985, the prison drug policy, Drug Free Detention, was developed. This policy has two main objectives, the improvement of control in prisons by preventing the use and dealing of drugs and rehabilitation of drug users by offering care and treatment.

The main instrument for realising this second objective has been the creation of drug free units. In Drug Free Units (DFU's), prisoners participate in groups of 8-12 members. Motivation to change is simulated and supported by the use of rewards and sanctions. Staff and fellow inmates challenge negative behaviours to improve prisoners' self-awareness and prisoners are given the opportunity to practise pro-social behaviour.

Some DFU's have introduced "sequence planning" to supplement these group processes. This focuses on the needs and ideas of the individual, using flexible, custom-made programmes, with an emphasis on the importance of continuing care on release. "Sequence planning" involves three elements, firstly a standardised assessment of problem areas, followed by the implementation of a treatment plan negotiated by prisoner and staff and finally; an evaluation process.

In evaluating the DFU programme the following conclusions have been made: DFU's create a positively valued, more open, less hostile atmosphere than that in the regular units. The use of drugs in DFU's is lower than in regular units; urine tests are vital in keeping DFU's drug free. Social pressure alone is not enough: DFU's are effective in providing continuity of care on release. 42% of DFU graduates continue to receive a treatment process, compares to 8% of prisoners released from regular units despite the consequent expectation the DFU prisoners would do no better in the long run than others. However, after 2 years there were no demonstrable differences in drug use, recidivism and psycho-social functioning (cf. van den Hurk 1995).

Drug treatment in the Prison of Favoriten (Vienna; cf. EDDRA ID 28761)

The first evaluation results of the Penal Institution of Favoriten (Vienna), which has specialised in the treatment of addicts (cf. EDDRA) showed that in 1997 and 1998 more than half of the clients could be prevented from relapsing into drug use at the stage of imprisonment under eased conditions. A project on "volunteer probation assistance" is run in the Penal Institution of Favoriten (cf. EDDRA) aimed at providing assistance during the months before and after release from prison. The evaluation has shown that the aim of continuing assistance after release could be met in only ten percent of the cases. The clients regarded this service as practical and useful, however, and indicated that it had helped them considerably to prepare for life "outside".

60 see also www.emcdda.org/eddra

61 EDDRA website available at www.emcdda.org

Drug Free Zone and Therapy Unit 'Drug Out' in the Prison of Innsbruck (cf. EDDRA ID 217 + 145)

In the Penal Institution of Innsbruck both the drug-free zone and the therapy department were evaluated. Since its introduction 260 prisoners have used the opportunities provided by the drug-free zone (cf. EDDRA), and the regular urinalyses showed that only 8.5 percent of them had consumed drugs (Justizanstalt Innsbruck 1999). From 1993 to 1997 40 addicted patients were treated in the therapy ward (cf. EDDRA), and at the time of evaluation eight of them were still being treated. Nine patients have been released prematurely because of lacking motivation, and three had died of overdoses in the meantime. Seven out of the 23 prisoners who were released under regular conditions were abstinent at the time of evaluation (i.e. approx. 30 %), one was obtaining long-term therapy, and three were undergoing substitution therapy. Four persons had been arrested again (cf. both descriptions National Focal Point of Austria 1999, 37).

Drug Free Zone in the Prison of Hirtenberg (EDDRA ID 57)

Since October 1995 a Drug Free Zone has been installed in the Hirtenberg Prison. The "Downview Project" (in Sutton, Surrey, England; cf. Lancaster 1995, 39) was adapted to local conditions. The concept underlying the drug free zone is based on a mixture of stimulation and incentives (privileges, improved quality of life) and monitoring (urine tests). Each inmate must sign a declaration together with a chosen staff member in order to increase compliance and to enforce trusty relationship between prisoners and staff. The reason for introducing such a project were problems in the prison: conflicts and aggression amongst prisoners and between prisoners and staff, small number of inmates were employed. In February 1994 96% of prisoners had contact with drugs (72% use and dealing, 24% dealing). The implementation of a drug free zone aimed at preventing drug use of inmates, reducing conflicts and improving working conditions of staff. In the year 1999 an average of 72% of all 262 inmates lived in the drug free zone. Since the beginning of the project until the end of 1999 791 inmates signed the contract to abstain from drug use and to undergo urine tests. 143 inmates (18,1%) have been excluded because of positive urine tests (61), discipline reasons (53) or they didn't get back from furlough (29). Three aims of the drug free zone have been formulated:

1. to create a setting which is supporting prisoners to stay drug free. Indicators for reaching this aim is the drop-out rate which has been reduced from 90% in 1994-1996/97 to 13% in 1996/97. The rate of positive urine test was <1%. A reduction of pharmaceutics could be noticed.
2. to increase compliance of inmates by improving their life quality and well-being and by strengthening their autonomy. The compliance is perceived as good, the drop out rate is 6% caused for disciplinary reasons of misuse of privileges.
3. to increase the number of prisoners included in employment. Over a three years period (1994-1997) there has been a reduction of unemployed inmates of 72%; a strong increase of productivity of work units could be noticed.

The Drug Treatment Programme at Österaker Prison/Sweden - Experience from a Therapeutic Community During the Years 1978-1998

The Österaker prison, situated about 30 kilometres north of Stockholm was originally built for 200 prisoners in 1969 but has been reduced and in 1976 a therapeutic unit on one of the wards for drug users has been installed. It was outlined as a therapeutic community within the prison system and the theoretical concept was within that frame largely based on cognitive behaviour therapy. The ward could

host up to 15 prisoners. The contents of the in-prison therapeutic community was copied either from outside therapeutic or psychiatric settings. Up till now more than 20 years of experiences and evaluations (done from 1978 to 1998) serve as a basis to value the impact of this in-prison treatment. Prior to being admitted to the programme every applicant has to write a letter explaining his reasons for change in the 8-10 month programme. If accepted every prisoner signed a contract according to which he had to conform to a few basic rules: no drugs (tested by daily urine tests), no violence, no threats, no conversation about crime if not as a part of treatment). An active participation in the treatment programme is achieved and every inmate had an individual treatment plan. Among the benefits of the programme were social visits (61/2 hours during the weekend), frequent furloughs (at least 72 hours every two months or every month if less than two years remains of the sentence). After completion of the programme most prisoners were placed in treatment institutions or families in the communities for 6 to 10 months. One of the most effective agents for change were prisoners themselves. If high status prisoners could be won for change and more or less identify as semistaff it was very effective. Also social control was experienced as an important factor for effective treatment in prisons. Special emphasis has been put on real life simulating role plays to strengthen individual resistance in temptation situation which necessarily occur outside. There have been several evaluation studies in order to check the rate of recidivism two years after conditional release from prison. Two studies for two different periods (1979-1981 + 1982-1996) compared the rate of recidivism of completers and Dropouts of the programme. The result was that the rate of inmates (completers and dropouts) with no recidivism after two years increased from 32% to 58,4%. Completers of the programme did better than dropouts with regard of avoiding recidivism (46% vs. 16% in the first, 66,6% vs. 35,4% in the second study). These results have been confirmed for a five years period comparing recidivism in crime of the experimental group with a control group. In total 45% of the prisoners in the experimental (treatment) group recidivated compared to 56% in the control group (inmates without special treatment programme but usual attention from social workers) in the period from 1985 to 1991). All in all practitioners supported by the presented evaluation results think that the behaviourist models like role playing and cognitive training make a fast and effective impact on prisoners' behaviour. Environmental factors are seen as crucial, the relative absence of criminogenic pressure has made it easier for the inmates to accomplish their individual treatment plans (cf. Farbring 2000).

The impact of the Edinburgh Prison Drug Reduction Programme

The Edinburgh Prison (Scotland) Drug Reduction Programme was evaluated to assess its impact on clients' drug using behaviour during their current prison sentence. Thirty Drug users who were being prescribed as part of the Drug Reduction Programme (DRP) and who had completed the Programme's educational and groupwork sessions were compared with thirty drug users who had not. Subjects were interviewed approximately a month after either completing the Programme (intervention group) or after being admitted to prison (control group). A smaller sample of participants drawn from both groups were interviewed again within two weeks of their release from prison. The intervention group had used a significantly lower number of drugs during their current sentence than had the control group, and was less likely to have used cannabis, dihydrocodeine, buprenorphine, temazepam, diazepam, and LSD, or to have used these drugs less frequently and in smaller amounts. When compared with other independent variables, not completing the Drug Reduction Programme was found to be the sole predictor of using cannabis more often and in greater amounts; of being more likely to have used dihydrocodeine and to have used it more often and in greater amounts; of being more likely to have used buprenorphine and diazepam, and a co-predictor of having used a higher number of drugs and of using

diazepam more often.

Other independent variables which were co- or sole predictors of drug use at the time of the first interview were all related to previous drug use. The previous drug use of DRP clients and the control group was broadly comparable, indicating that completing the DRP is associated with reducing the reinstatement of previous behaviour. Prior to release, the differences in drug use between DRP clients and the control group had largely been maintained, and not completing the Programme was still a co-predictor of having used a higher number of drugs. The Edinburgh Prison Drug Reduction Programme provides a model which could be adopted by other prisons. This follows the principle argued for by the WHO of providing health care in prison comparable to that available in the community, and also enables the development of prison-based drug services which can have a beneficial effect on clients' drug using behaviour (Shewan/Macpherson/Reid/Davies 1996).

Methadone Maintenance Treatment (MMT) in Prisons

Dolan/Wodak/Mattik/Hall (2000) reported from their randomised controlled trial of the NSW/Australia prison methadone program aim to measure the impact of methadone on: HIV, HCV incidence, use of heroin, use of drugs and risk behaviour. Methods male heroin injecting inmates serving at least 4 months were recruited, interviewed and provided scalp hair samples to be tested for heroin metabolites and finger prick blood samples to be tested for HIV and HCV. Subjects were randomly allocated to four months methadone treatment or a wait list. Results: 384 subjects were enrolled. Groups were identical at baseline. Mean age was 27 yrs, 25% were aboriginal and 10% reported starting injecting in prison. One subject had HIV infection on entry to the study. Three quarters of subjects (74%) had HCV. 85% of treated subjects and 79% of controls were followed up. Self reports of injecting heroin between interviews was 39% among treated subjects and 72% among Control subjects. HCV incidence was 24/100 person years among the Treated subjects and 48/100 person years among the Control subjects. No subjects acquired HIV infection. Conclusions Randomised controlled trials of prison methadone programs are feasible. In NSW prisons, heroin use, HCV infection and HCV transmission are common but HIV infection is rare. Methadone maintenance treatment prevents hepatitis C transmission in prison. There are grounds for expanding or introducing prison methadone program in Australia.

In-prison treatment by a private treatment institution: Evaluation of Kongens ϕ in Denmark[62]

During the autumn of 1998, the pilot project was the subject of an external research evaluation. This evaluation covers the period from November 1998 to May 1999 - that is, the middle one of the three pilot years before the expansion by another unit. Obviously, it is not possible so early in the project to make any conclusions on the long-term effects of the treatment. Therefore, the evaluation is mainly to be viewed as a process-oriented evaluation focusing particularly on the implementation and running in of the project.

The evaluation report, entitled "Punishment and treatment of abuse under the same roof", was prepared by a university lecturer from Arhus University. The Ministry of Social Affairs, which was represented in the monitoring group, as mentioned above, funded the evaluation. During the entire pilot period, the largest problem of ensuring maximum quality of the project has been the difficulty of establishing

[62] carried out by Anette Storgaard, she wrote a supplementary report about the Kongens 0-project

constantly good conditions for making agreements with the inmates[9] home authorities on follow-up treatment.

The best results have been achieved in cases where the inmate has passed from the prison to the Kongens 0 institution outside. In cases where inmates have passed straight to the outside or into other treatment, recidivism to new (but not serious) offences was rapid.

The evaluation concludes that the present material of experience points strongly to the fact that a stay in a Kongens 0 unit provides a better opportunity to "make a fresh start" after the incarceration. An essential condition for success seems to be follow-up treatment.

Conversely, there is no basis for concluding that a stay in a treatment unit guarantees a drug-free and law-abiding future. There is no doubt, however, that the present treatment concept fulfils the partial goal of freedom from drugs during incarceration:

- The evaluation period comprises 38 drug addicts admitted to the programme.
- Of the 27 that had left the unit, 14 had left according to plan. This means that they either stayed in the unit until their sentences were served, or they had been transferred to continued service elsewhere by agreement with the staff.
- Nine had been expelled from the unit, and four had left at their own wish.
- Half of those admitted were convicted of robbery, most of the others of other offences against property, and the average sentence length was *3V2* years.
- There is a clear correlation between an early start of addiction and heavy offending on one hand, and on the other a late start and lighter offending. In 11 of 17 cases that give this piece of information, the person started using heroin before receiving the first prison sentence.

The staff who have participated in the project are generally extremely positive. The day-to-day collaboration has worked well. Both the mutual relations between staff and relations between staff and inmates are assessed by all as much better than under conventional terms of incarceration.

The project saw some introductory problems of information and communication between the prison and the local authorities that refer to and grant treatment and decide on continued treatment after the release.

The evaluation states that these problems could have been avoided if more formalised information had been sent to the counties from the central authorities when the project was launched.

To make up for the starting difficulties, the after-care probation service and the authorities referring to treatment have continuously adjusted and mutually adapted procedures on a practical level. Work has been done to improve the flow of information, and the local authorities now draft a recommendation concerning the action plan following personal contacts.

Based on the evaluation of the project, the idea now is that the monitoring group should consider as soon as possible whether any adjustments are needed.

As an overall objective, the performance contract of the Danish Prison and Probation Service for the period 1999 to 2003 states that efforts of after-care and treatment must be strengthened, including the efforts against drug abuse.

The expansion of the Kongens ϕ project is actually part of this objective. Moreover, several other initiatives have been started, also aiming to strengthen the efforts against drug abuse. The most interesting proposals in this connection are the three following:

Needle exchange projects in Germany, Switzerland and Spain

Summarising practical experiences and results of scientific evaluations in Germany, Switzerland and Spain show (Meyenberg et al. 1997/1999; Nelles et al. 1995/1997, Zeegers Paget et al. 1996; Carrón 2000, Stöver 2000):

Feasibility: In all prisons attacks on staff or fellow inmates by drug- users using needles as a weapon did not occur. No scenarios of threatening appeared in any of the 19 prisons running needle exchange schemes so far. It was not necessary to exclude participants from the needle exchange project because they did not follow the rules of the projects. During the project the controls of cells were not increased; the number of drug finds did not rise either so that the fear that the availability of clean needles resulted in an increased drug use was not confirmed.

The implementation of the needle exchange programme as part of the general health service for addicts in detention did not have a negative effect on the onward referral of drug users to follow-up treatments, this is the result from the German projects. On the contrary, it can be stated that after the project has started the number of drug users undergoing follow-up treatments has increased. As regards home leaves etc. in detention, the participants in the needle exchange programme were not treated differently from other drug users in prison: controls of the cells of project participants were not increased.

Acceptance of the Measures: The level of acceptance of the German projects differed. Considering the frequent use of the dispensing machine in Vechta and the positive statements the project participants made in this prison, it can be concluded that the acceptance of the needle exchange programme was much bigger in the women's prison than in Lingen. Here - perhaps owing to the different mode of distribution - the drug users took a much more reserved stance towards the project. Many drug users were very reluctant to formally declare their participation in the project and some tried to participate in the project secretly by asking others to supply them with sterile needles provided under the project. *"...but there will be no such thing as total anonymity. But that´s got nothing to do with the implementation of the project; that´s got to do with transparency within prisons, that many things are known." (a prisoner, Meyenberg et al. 1997, p. 270)* They fear negative consequences for getting known and registered as drug users. Although the staff of the internal drug counselling service has been integrated into the medical confidentiality and the information of a participation in the project is neither recorded in the personal nor in the health file, prisoners don't want to get known anyhow by the other staff members, who potentially decide about home leave, cell controls and drug testing. Absolute anonymity, however, is not possible in prison. The main advantage of the distribution mode of dispensing machines against hand-to-hand-provision is the greater anonymity for the inmates. This is the reason why the male prisoners are very cautious in accepting the hand-to-hand distribution. It will take a longer time to reduce this mistrust of the needle exchange facility.

At the beginning of the project the participants were informed that the syringes must be stored at a clearly specified site (on the washbasin console or in a lockable closet). This provision was not made to control prisoners but to avoid that prison staff searching the cells come into contact with used needles.

Not only for this reason anonymity is hard to reach. In both prisons the exclusion from the needle exchange project of detainees being in methadone programmes is practically impossible, because they are not and should not be isolated. There are some indications of injectable drug use of them. It doesn't seem to be a problem for them to get clean needles from participants of the needle exchange projects.

Most of the detainees follow the rules determining the supply of sterile needles. Only a few "special occurrences" could be noticed - mainly these refer to inadequate storage of syringes in the cells.

Not a single threatening scenario occurred although thousands of needles have been handed out to inmates.

During the study period **the number of drug finds did not increase**, which indicates that the drug use and the drug market has to be seen independently from the availability of sterile injection equipment. For the staff the needle exchange programmes became in a very short period part of everyday life - the character of extraordinarily of the pilot project has vanished - a process of normalisation can be observed.

The medical evaluation clearly states that **the number of abscesses decreased dramatically** and that only one seroconversion could be observed during the 2-year pilot phase an improvement of health status of prisoners can be noted for those participants being permanently in the exchange scheme. Generally an improvement of health status of prisoners can be noted and an improvement of health knowledge can be achieved.

The Swiss and the German evaluation of the projects found a dramatic **decrease of needle sharing** among those prisoners participating in the needle exchange programme.

In all needle exchange programmes, the **importance of supporting preventive measures** and information programmes has been stressed.

No increase in the number of accidents with needles lying around. Based on a 1:1 exchange the number of used needles returned was high; the fear that drug users might not handle injection equipment adequately was not confirmed. The only violations of the regulations that occurred in Germany during the project were that the syringes were not stored in the places that had been agreed upon and that prisoners participating in methadone programmes had syringes in their possession.

CONCLUSIONS

“Prisoners are part of our community, they come from the community and return into the community. They deserve the same level of information, protection and care than everybody outside prison gets. Communicable diseases in prisons should be considered as a general public health issue and not only restricted to this group of population.” (Cees Goos, WHO)

Time spent in prison directly effects the broader community: housing opportunities are lost, wage earners are separated from their families, children are raised in the absence of a parent; mother and child are separated, employment opportunities are destroyed. Prisons often have a major destructive influence on individuals and community. For drug addicts the prison setting constitutes even more a difficult setting: they have to cope with their illness under restricted circumstances and limited resources: the differentiation of the drug service system outside is not implemented in the prison setting yet. The wide range of drug services developed in most European countries is mainly reduced to drug free services. This is not a coincidence because the goal of staying drug free is identical with the goal of the penitentiaries to lead a life in future without committing criminal offences. Purchasing illegal drugs is a criminal offence per se in all EU-countries. Because of this identical goal, it is difficult to transfer other forms of treatment into the prison setting which is either substituting illegal drugs or acknowledging drug use and developing harm reduction measures.

Despite these limitations it is necessary to rely on basic tasks prison authorities have to fulfil against every prisoner:

- prisoners should be treated with respect by all levels of staff,
- prisoners should be encouraged to improve themselves
- prisoners should make contact with their families, partners and relatives
- prisoners should feel safe inside prison.

Documentation and scientific research data

Cross sectional views of drug use and health problems mainly at admission are widespread whilst longitudinal perspectives of the development of drug use patterns and drug users careers in prisons as well as analysis of health data is very poor. For a comprehensive understanding of the dynamic, meaning and impact of drug use and risk taking in prison also qualitative studies are necessary. Van Alem et al. (1999) argue that the reason why only few aggregated data are available is the highly decentralised way in which detention centres and prison collect and aggregate their own data. Only a few exceptions on a European level (i.e. Sweden) can be noticed. The lack of aggregated data makes it difficult to monitor major changes, to describe developments and to compare intervention outcomes. Medical checks for example at the end of the sentence are not carried out regularly due to practical problems, so often there is no overview of health process of prisoners. van Alem et al. (1999, 14) suggest to connect the criminal justice system and their treatment and inmate health data with the broader information systems existing in every European country either on a regional or on a national level. In every country monitoring systems do exist which allow at least trends to be identified and treatment needs and outcomes to be documented. They propose the extension of the national databases within the framework of the existing National Drug Monitor (NDM) as well as the European context, where since 1997 a core item has been set to monitor treatment demand (EMCDDA, 1998).

Definitions

The design of a common methodology through which it would be possible to collect reliable information on a regular basis on drug use in prison would first include a consensus of the term ‚drug user' or even ‚drug'. Although officials in many prisons claim to have severe problems with drugs and drug users in prison, widely differing definitions are applied. Throughout European prison administrations terminology is very heterogeneous due to different definition baselines and views of problematic drug use and time of assessment. In assessing the percentage of drug using inmates, looking solely at the number of drug related convictions and committals largely underestimates the extent of the drug problem in the prison population.

Organisation and practice of health care and assistance provided to drug users in prisons

In all but three European countries the health care matters are lying in the responsibility of the Ministry of Justice. Prison administrations and health care units undertake many efforts to ensure best health care and treatment. Many drug using inmates benefit considerably from medical care, counselling, treatment and interventions in prison. However, structural problems remain, basically for the doctor-patient/inmate relationship in prison in terms of a close and trusting co-operation between doctor and patient. Doctors can not freely be chosen as in the community and inmates often mistrust medical confidentiality and suspect a close co-operation with prison administration. These problems can be reduced with an extended co-operation with community services, an exchange of information and experiences and a close collaboration in counselling and treatment efforts. This seems to be consensus throughout Europe that a close co-operation of prison drug treatment services and relevant community services have to be established in order to facilitate dialogue and throughcare for persons treated in prison for drug dependency. This can be characterised as 'holistic' approach. In some drug strategies the need for an establishment of special liaison groups with relevant community interests is felt to be appropriate. Prison medical care (treatment, counselling, interventions of any kind) often remains intransparent and the outcomes poorly evaluated. To ensure quality of the professional work documentation and evaluation, steady training, exchange of information and experiences, seems to be necessary. This ensures moreover the steady contact with treatment demands and standards.

It is essential that standards of care for prisoners reflect the care provided in the community. The prison health services therefore should be encouraged to be organised in close relation to health care in the wider community. Some critics go even far beyond that and demand a change in prison health care to tackle drug use related problems better in shifting responsibility from the Ministry of Justice to the Ministry of Health.

It seems to be of great benefit when as done in some countries concerted action is taking place (steering groups or strategy units) with the task to observe and monitor the developments and possibilities of an improvement of health care for prisoners and especially for drug using inmates.

Drug users in prison

Despite heterogenous definitions drug users in prison constitute a major problem in terms of security for the prison system and health risks for the inmates. Although nearly every EU-country developed diversion approaches and is putting emphasis on the treatment need, the number of those finally ending up in prison is high. This reflects on the one hand increasing sentencing policies on the other hand the fact that drug users are often excluded from alternative sanctions (like electronic monitoring, community sanctions) or open prisons. This leads to an increase in the number of drug using prison population. Characteristics of this group is highly socially deprived with severe health damages and often several stays in prison and

treatment attempts, and finally high relapse experience, with severe health damages (including irreversible infectious diseases). Drug users are supposed to be the biggest homogenous group of the prison population. Generally this group serves relatively short sentences, which often makes treatment planning difficult.

Health risks

- *drug use*

Although the term 'drug user' is not clear in every report on drug use within European prisons, it can be assumed that approx. 15 - 50% of the 350,000 prison inmates in Europe use drugs or have used drugs in the past. Considering the high number of prison entrances and releases (turnover rate), 180,000 - 600,000 drug users go through the system annually. Cannabis seems to be the most widespread drug, followed by heroin and other opiates, benzodiacepines and polyvalent drug use; stimulants seem to play a minor role. Up to two thirds of the inmates in some countries report a history of alcohol misuse prior to imprisonment.

- *Risk behaviour*

Risk behaviour of i.v. drug users in prison (drug and needle sharing and unsafe sex) is reported by many prisoners. Injecting drug use in the prison setting mostly means sharing of the needles/syringes, the injecting equipment and sometimes the drug. Reports of unprotected sexual contacts and unsafe tattooing techniques are also quite often Risk reduction and education programmes have to be introduced resp. enhanced. Anonymous and voluntary identification of risk behaviour, HIV/Hepatitis B and C education and screening, incorporating access to prevention means should be offered to all inmates, both IDU and non-IDU, in line with the prevention policy developed in the community and recommended by national and international boards.

- *Infectious diseases*

HIV infection in prison remains a major issue, especially in Southern European Countries (Spain and Portugal). Moreover Hepatitis B and C are the central challenges of infectious diseases in all European prisons. Seroprevalence rates of both HIV and Hepatitis B and C are many times higher in prisons than in general free living population. In many prisons this development has been underestimated and hasn't been taken up in specific prevention messages and vaccination procedures (agains Hep. B). Although needle sharing is a major route of transmission of HIV; HBV; HCV, accompanying risks of sharing of equipment, drugs, filters, water, spoons, swabs etc. or even through household contacts have been identified as additional transmission routes to HIV.

The debate on HIV/HBV/HCV infection and prevention in prison is even more delicate than in general population, because it is indicating on the one hand that injectable drug use occurs in prison as well and on the other hand that prison is a problematic setting to put infectious diseases on the agenda without being identified as drug user with all negative consequences. The debate about the spread of infectious diseases among prisoners is necessary, not only because of the consequences for the public health but also because of advocacy for people living in poverty, overcrowded areas and under poor social conditions.

- *Drug related deaths*

The conditions of imprisonment not only influence the risk behaviour of drug users in prison but also drug-related mortality rates inside and outside prison. On the one hand the time spent in prison protects drug users against infections because in this environment drugs are sometimes hard to come by so that drug

users are forced to do without drugs; on the other hand, however, the drug shortage in prison which induces consumers to be less cautious in drug consumption, increases the risks involved in drug use. Prisoners who have not taken drugs during detention frequently find it difficult to adapt to the new situation after release; they return to old habits and consume drugs in pre-detention quantities and quality or personal contacts to dealer have been disconnected during imprisonment and the grade of purity of new dealer is unknown. The transition from life inside prison to the situation outside prison is an extremely sensitive period.

There is a enormous lack of preventive measures (including training on 'safer use' and preparation of a possible relapse after release) offered in prison. External drug counsellors are often working in the interface situation at release guaranteeing the continuation of treatment and contact inside and outside. Often there doesn't exist a concept of risk counselling for the first days after release This seems to be the crucial point for low threshold offers as well as for therapeutic communities in custody.

If there is some expectation of life-time benefit, then great effort needs to be devoted to the post-release period. However, it is unrealistic to expect community agencies to take-up that challenge unless they have accessed the inmate during the period of imprisonment. So Public Health Associations should be encouraged to start working with prison authorities in devising standards for health care provision.

The principle of equivalence

The principle of equivalence means that the health care measures (medical and psychosocial) successfully proven and applied outside prison should also be applied inside prison. With regard to support for drug using inmates in many ways this has turned out as wishful thinking. In most of the countries already basic prerequisites are not given (i.e., no throughcare of treatment, no adequate prevention means).

Nevertheless the principle of equivalence is the guiding criteria, with which prison drug services have to be measured in the context of the national drug service structure and the drug policies pursued in all EU member states. Especially the differentiation of drug services (including drug free treatment, methadone maintenance and harm reduction) outside is not reflected sufficiently inside prison. 'Prison Health' has to be integrated in the broader frame of 'Public Health'.

Organisation of assistance to drug users

If imprisonment itself couldn't be avoided, then treatment and preventive steps have to be taken from the first day of imprisonment. That includes comprehensive medical care as well as access to health and social worker both from inside prison and community services in order to plan the individual psychosocial perspectives. This dual intervention of inside and outside drug services seems to be a successful strategy in tackling the health problems of drug users in prison and afterwards. This is more and more applied and the awareness has been raised in recent years. Especially the increase in substitution treatments outside has lead to the necessity of inside reactions to this form of treatment.

Medical care

The poor health education and the lack of information about the various treatment and prevention facilities in prison (i.e. Hepatitis B vaccination, substitution treatment, treatment of Hepatitis C-patients) currently reduce the potential impact of a stay in prison in terms of access to health care services. Prison medical care could play a much more bigger role in stabilising drug users. The offered voluntary

screening (HIV and hepatitis) of inmates is a chance to assess possible infection risks. Although specific counselling offers in order to start a dialogue with the inmate can be made, screening of infectiological parameter is often perceived as control measure by the inmates.

With regard to medical treatment (not only of HIV) increased efforts need to be undertaken in prisons to ensure that prisoners receive care, support, and treatment equivalent to that available in the community. This includes:

- Making sure that inmates in pain have equal access to narcotics routinely given for pain relief to patients outside,
- allowing inmates equal access to investigational drugs and nonconventional (complementary and alternative) therapies,
- ensuring that inmates have access to inform on treatment options and the same right to refuse treatment as exists in the community
- assessing health care services in each prison in consultation with outside experts, to ensure that the expertise necessary for the care, support, and treatment of inmates with HIV/AIDS is available, accessible, and efficient.
- In the longer term, correctional health care needs to evolve from a reactive sick-call system to a proactive system emphasising early detection, health promotion, and prevention (cf. Canadian HIV/AIDS Legal Network 1999)

Drug free treatment

Services addressed at drug users are basically abstinence oriented. There is much debate up till now about the usefulness of the abstinence approach in terms of a realistic and achievable aim for all the drug users described above. Moreover there is only very few research (including time periods after release) about the effectiveness of this approach and the possible adverse effects.

Drug free treatment differently organised form the dominant approach towards drug users in prison. There are different models of drug free wings/zones, either in the regular penitentiary or in special establishments. The concept of drug-free units (DFU's) which have been settled in several European prisons (e.g. Austria, Portugal, Scotland, The Netherlands) seem to be very well accepted by medical and prison staff, and administration. The available data suggest that DFU's provide adequate protection from drugs and that they are relatively successful in realising continuity of care.

Studies in the US revealed that Therapeutic Communities in prison are not effective on it's own: those treatments have had preventive effects for which a complementary adjusted follow-up treatment after release has been organised ('The group that did the most did better'; Turnbull 2000). That means the after care component is crucial if therapeutic efforts should have an effect on recidivism of both addiction and crime.

Substitution treatment

Substitution treatment includes three forms: detoxification, maintenance and a treatment initialised in prison as adequate form of medical care and relapse prevention. Substitution treatments offer an opportunity to regularly discuss health and drug-related topics with the prisoner, as well as proven measure for the reduction of use of injectable drugs.

Drug using prisoners who were receiving treatment in the community prior to imprisonment are often and in most countries not able to continue with their treatment in custody even in countries with an extended prescription policy outside. Substitute prescribing is often designed at the provision of symptomatic treatment or short term methadone detoxification in the admission phase. Imprisonment therefore is very likely to result in discontinuation of substitution treatment. Still an abstinence orientation is dominating the medical care. Substitution is often seen a s prolongation of the addiction, while imprisonment is supposed to be useful for staying or becoming drug free. The criteria for the prescription of substitutes is often perceived as intransparent and arbitrary. National guidelines are necessary, but guidelines are not enough on their own, they need local adaptation and implementation.

Methadone maintenance is a medically indicated form of treatment that should be available to opiate-dependent people regardless of whether they are outside or inside prison. In addition, opiate-dependent prisoners should have other treatment options, including methadone detoxification programmes, with reduction-based prescribing, which should be routinely offered to all opiate-dependent prisoners on admission.

Transfer of harm reduction measures into prisons

According to some European studies approximately half of the drug users don't stop their use of injectable drugs, mainly opiates when entering prison. Although consumption appears to be realised to a lesser extent, basic health risks remain: Prisoners experience a 'hygienic relapse' while having a regular and low-threshold access to needle exchange programmes in the community, preventive means are not available in the prison setting and addiction related risk taking occurs. In line with the WHO recommendations on 'HIV and AIDS in Prisons' (1993) harm reduction measures have to be considered when applied in the community.

Based on epidemiological and sociological studies on the spread of infectious diseases and dynamics of (injecting) drug use patterns, there is an overwhelming evidence for the introduction of Harm Reduction into prisons. Present prison drug services are too much focussed on abstinence oriented measures. A dual strategy of cure (abstinence) and care (harm reduction) is needed. But apparently at the moment harm reduction measures throughout European prisons are developed only poorly. Needle exchange schemes are only introduced in 19 prisons in Germany, Spain (and Switzerland). Bleach is a measure applied also only in a few countries and very little is know on the concrete use of disinfectants. Even the provision of condoms is not covering all prisons and again the .everyday access has to be checked properly. Bleach needs to be made easily and discreetly accessible to inmates in all prisons

Basically harm reduction measures may be seen as an opportunity for treatment options. In low threshold interventions like provision of sterile syringes and needles, condoms, bleach is a chance to reach also those addicted prisoners for ongoing counselling and intervention, who couldn't be targeted by the prison health care staff, because they were unknown drug users. This seems to be a group which is vulnerable at contracting health damages after release, because no therapeutic relation has been developed. Bollini (1997, 12) suggested on the basis of her four-country study the implementation of demonstration projects based on the WHO guidelines of 1993 under the supervision and co-ordination of UNAIDS and WHO. "The presence of international organisations would provide symbolic and scientific authority to the program, and would ensure effective dissemination of its results. It is important to stress that harm reduction projects in the participating countries should not necessarily be the same, but should respond to the current needs of each partner. Each project should implement, and duly evaluate, one aspect of WHO Guidelines".

Knowledge

Many studies reveal the poor knowledge on effects of unsafe drug use, sex and transmission of HIV and Hepatitis, both of inmates and staff. For prisoners time of imprisonment should be utilised as time for education and information. This is not simply done by handing out leaflets and other written material about health risks and where and how to get medical treatment and social support. Education affords well structured efforts to improve knowledge about relevant topics with different means (audiovisual approaches) and strategies (campaigns, inside/outside collaboration).

The setting oriented 'Health in Prison' approach

One attempt by public health practitioners to address the challenges of prisons, has been within the broader healthy settings movement, that has given rise to better known initiatives such as "Healthy Cities". A 'total institution' (Goffman) like prison has to be viewed as a system with people working and living in it. The concept of "Healthy Prisons" is therefore focussing on the achievement of health promotion in prison both for the in prison living inmates and working staff. This includes also advocating for prisons to be safer environments, both for prison inmates, and their communities. Ideally, a "Healthy Prison" should serve the general community by targeting health-improving interventions to a high-risk sub-group (i.e. drug users) of the community. It should minimise the health deficit, and maximise the health gain. Health promotion recognises the social and environmental impacts on health. Recognising that the health behaviours of populations are determined by their environment. Changes in the environment will be necessary to effect health change. Change in the prison environment will require changed public policy, which will only occur with community support and political commitment.

A case can be developed that a healthy prison is a more manageable entity, with the result that security is enhanced. This is a tantalising suggestion for custodial authorities.

In Sydney Australia, in 1991 a prison guard was injected with HIV+ blood by a mad prisoner. The prison guard later died. This incident is used by prison authorities to ban clean injecting equipment in prison. As a result, contaminated equipment is shared around, and HIV and hepatitis C can be transmitted. In contrast, since 1994 prisons in Switzerland, Germany, and Spain have been providing clean injecting equipment to inmates. This allows prison officials to concentrate their efforts on security around drug trafficking, while the health staff can offer harm minimisation options equal to those found in the community.

Given that the majority of prison inmates return to the community after quite a short time, the dangers of the prison environment are easily reflected onto the general community. The need for engagement is compelling.

Promotion of health care for drug users also includes that the prevailing conditions in prison are studied more closely to find out which factors put inmates under stress or induce them to take greater risks. These factors then need to be eliminated.

- *Stabilisation of Drug Addict's Physical and Social Condition*

Promotion of health care should be designed to improving living conditions in detention in general because many inmates are hopeless and desperate and do not believe that they can improve their situation permanently. This may be one reason for the increased readiness of inmates to take greater risks and to dismiss the implications.

The areas to be investigated are:

- housing (cell, block, office, place of work)
- suitability of food
- hygiene and cleanliness
- sanitation
- autonomy (competence, residence)
- architectural and environmental issues (building, heating, sanitation, light, ventilation etc.)
- spare-time, offers for weekend activities, activities offered after 16:00 h
- physical exercise, sports
- visiting and leave regulations
- availability of therapeutic treatments
- medical treatment in general.

However, it will not suffice to only look into the options the individual prisoner has of changing his/her behaviour. Instead "structural prevention" is required, i.e. the actual living conditions of prisoners and the necessity for behavioural changes must be investigated. By only looking into the individual's options for changes in behaviour the blame is put on the prisoners who act "risky" and "desperately".

- *Differentiation inside Prisons*

Due to the varying requirements of (formerly) drug-addicted prisoners different forms of housing should be available. Those prisoners who intend to live abstinently and prove to do so by testing negative for drugs should be given the opportunity to live in "areas with a low drug availability", just like those prisoners who intend to undergo a therapy outside prison to become drug-free or who prepare for open detention.

Prisoners who show little willingness to change their behaviour should be offered information on "safer-use practices" as well as stimulation and basic self-help in how to take care of their veins, etc. in order to avoid unnecessary and possibly irreversible damage and to encourage prisoners to use clean equipment. Generally the problem of overcrowding is a fact which in many prisons makes it impossible to differentiate.

- *Networking between Drug Service Providers inside and outside Prisons and Adjustment to the Standards applied outside Prisons*

The needs of the health and the justice system have to be balanced. This affords that also different professional cultures have to be balanced: social worker, psychologists versus prison officers and administrative employees. This is one of the basic prerequisites for a change in the health care for prisoners. The help provided to drug users inside prisons should be balanced with the support services available outside prisons. The special status of support services inside the walls can only be overcome if all the services available to drug users outside prisons are also made available to those inside. A bridge from prison to community has to be provided. In particular outside experts should also offer counselling and care inside the walls. This can only be achieved if all parties involved are willing to co-operate, a precondition which is not speaking for itself.

A policy of demarcation is not only pursued by prison managers but also by service providers outside prisons who disregard inmate drug use, mostly because their experience of the control and security

regime of prisons has been negative. Hence it is difficult to balance support services inside prisons with those outside prisons. In the presence of mistrust and a reluctance to pass on information, co-operative links from which both parties could benefit and which are urgently needed cannot be established. However, it must be considered that a co-operation between outside experts and the trained staff in prisons requires compatible working strategies. Despite the different conditions inside and outside prisons concepts that can be implemented in both areas must be developed.

Networking between service providers inside and outside prisons is particularly important to imprisoned (drug-addicted) women: Since their average period of detention ranges from 3 to 9 months (owing to the short time available a detention schedule is not made), the goal that is pursued from the beginning is to prepare them for the time after detention. This can be done most effectively if the service providers inside and outside the walls co-operate. As regards the health status of inmates for instance, a methadone treatment that was started during detention could be continued without interruption after imprisonment. Inmates could be prepared for a therapeutic treatment after detention; gynaecological and dental treatments as well as the treatment of diseases resulting from illegal activities would be possible, just like healthy nutrition and offers for spare time activities.

As regards social aspects, co-operating service providers inside and outside prison could help (former) inmates to cope with the loss of family ties (to their children, partners, their original family) and to avoid isolation.

The rising extent of problems among this group (imprisoned, drug-addicted women) stems from their social situation prior to imprisonment: Impoverishment, which mainly becomes apparent through increased homelessness, and frequently, lacking financial security. Securing existence and providing compensation for the under-supply situation of the affected men and women are the main goals to be achieved by social service providers responsible of preparing inmates for release. Another objective that might be achieved by granting increased home leaves from prison and suspension of detention respectively (safety aspects are not a real obstacle to this) may be better chances of former inmates to find a job or occupation.

Finally it must be mentioned that premature release (mainly as a result of participation in a methadone therapy) after two thirds or half of the sentence has been completed, is handled in an exemplary manner in some women's prisons.

- *Opening up Prisons to outside Groups and Service Providers*

The drug addict must be able to realise that the steps he/she has to take can be taken and that they open up new prospects. To orient towards the outside world is a strong motivation for prisoners.

To date drug addicts in detention have been a group, which - in contrast to other inmates - was only rarely granted home leaves and other privileges of detention, open detention or premature release. The negative test results of urine controls which frequently also included testing for cannabis residues (which can be detected up to 30 days after consumption) and which were required to be granted these privileges have been and still are a major hurdle that is difficult to take.

The objectives of service provision mentioned at the beginning, strengthening the inmates self-esteem and autonomy, would be reduced to absurdity if possibilities for acquiring and testing (their) physical skills

were not accessible to prisoners outside the walls. It seems that NGO's are important in pushing development and introducing change in prison and in the relation of the different perspectives arising from health and justice matters.

- Analysis of current and future innovative treatment programmes is needed

In some countries documentary very few evaluation is carried out on the effectiveness of the outcome of treatment and intervention measures. Although the 'drug problem in prisons' commonly is perceived to be very high and a lot of efforts are undertaken to reduce health risks associated with that, very few evaluation on the effects of these efforts is done. Evaluation has not always to be carried out by large scales studies. To set up specific project groups with the aims of carrying out surveys of drug use, current state of affairs of interventions and to submit proposals for new treatment initiatives and co-operation with outside agencies seems to be necessary[63].

- Research is needed

For a better understanding of how drug users manage to stay drug free and why others do not, more research is needed. Some of the key topics are the following:

- Epidemiology of health risks in the prison setting (cross sectional and longitudinal)
- Identifying key figures for monitoring system
- Better understanding of drug use patterns (drugs, frequency, amounts, routes of administration)
- Evaluation of the long-term effects of interventions and derivation of 'Good Practice'
- Effects of peer education and peer support
- In-prison treatment and intervention monitoring: what works and why?
- Identifying obstacles of a transfer of harm reduction measures into the prison setting
- Cost effectiveness and cost benefit of in-prison and aftercare programmes

[63] For instance like in Denmark where in 1999 a project group was set up with the task of carrying out a large-scale analysis of previous and current drug treatment regarding drug addicts in prison.

APPENDICES: EUROPEAN GUIDELINES AND RECOMMENDATIONS

The following recommendations have been elaborated by experts either practitioners, scientists or prison administration staff throughout Europe on various conferences and working group meetings. Many of the recommendations and guidelines developed fit into the conclusions being made in this study. They are a resource for all those working in the field of drug services in prison in Europe, and will be promoted by the different European networks. The list is ordered chronologically.

A1 PRISON AND DRUGS 1998: EUROPEAN RECOMMENDATIONS (THE EUROPEAN NETWORK OF DRUG AND HIV/AIDS SERVICES IN PRISON/CARL VON OSSIETZKY UNIVERSITY OF OLDENBURG)

The Prison and Drugs 1998 Conference in Oldenburg (12-14th March 1998) gathered together 109 people to discuss prison drug services and to make recommendations on them. These people included senior officials from prison administrations, prison doctors, prison officers, managers and staff of non-governmental organisations, probation officers, social workers and representatives of drug user organisations. They came from twelve member states of the European Union and three other countries. Recommendations were drawn up in workshops on the following topics:

- harm reduction in prison.
- drug-free treatment in prison.
- substitution treatment in prison.
- needle exchange in prison.
- peer support in prison.

Across the workshops, there was agreement on the following general principles:

1. That a wide range of drug services should be available to prisoners, based on local and individual need.
2. That health services for prisoners should be equivalent to those provided outside prisons.
3. That there should be continuity of treatment for prisoners entering and leaving prison, involving cooperation between prisons and external agencies.
4. That there should be training for prison staff and prisoners on drugs and related health problems.
5. That drug services in prisons should be subject to monitoring and evaluation.

The following report of the Conference is split into six sections. The first gives general recommendations that were made in individual workshops. The next five give the recommendations that were made under each topic heading.

A. GENERAL

1. Prison should be seen as one part of a continuum (from society to the criminal justice system and back again). This continuum should provide a process of pro-active interventions, including assessment, admission, treatment, relapse prevention and aftercare.
2. Policy and strategy to tackle drug misuse in prison should be backed up by legislation and should ensure that national minimum standards for treatment and security are implemented in all

establishments. Additionally, there must be room for individual initiatives, pilot projects and innovative programmes.

3. Programmes should be provided according to individual needs. Offending behaviour might not be drug-related. If this is the case, both the other causes and the drug abuse must be treated.
4. The subject of addiction must be included in the further education and training of prison staff, including medical staff.
5. There must be regular opportunities for exchange of information and best practice between prisons and outside agencies at all levels.
6. Prisoners' health is paramount, so treatment options and access to them must be sufficient and based on the same quality standards as in the community.
7. Treatment options must be geared towards the needs of individual prisoners.
8. Legislation should be introduced to enable flexible release of prisoners, thereby actively encouraging successful participation in offending behaviour programmes.
9. Prisoners should participate in treatment on the basis of voluntary and informed consent.
10. Treatment in prison is not an alternative to community treatment. They are complementary and both necessary.
11. Directors of Prisons should undertake full and constructive dialogue with staff to ensure that any national initiative is implemented locally with full support and ownership by the establishment.

B. HARM REDUCTION STRATEGIES

1.Responses to drug users detained in prison should acknowledge that prisoners come from the community and will return to the community. Policy and practice should therefore aim to reduce the harm their drug use does to themselves, to other prisoners, to prison staff and to the wider community.

2.Harm includes:

a) Infection transmission
b) Damage to the individual drug user
c) Impact within the prison and upon the wider community

3.Harm reduction includes a range of interventions that impact upon an individual drug user's behaviour. Such interventions would include prevention, education and treatment. Full consultation should take place with external drug and other agencies to ensure that prison programmes reflect those available within the community.

4.The design, planning, implementation and evaluation of harm reduction strategies need to involve all relevant and appropriate individuals and groups.

5.All those directly involved need to develop clear protocols for practice, with a transparency of roles and responsibilities.

6.Prior to the implementation of harm reduction strategies, there is a requirement for appropriate preparation at local` level. This preparation would include training, education and resource allocation appropriate to local need.

7.Services and interventions should reflect the wide range of types and methods of drug use and respond to changing patterns and trends of use in the future.

8.Following a comprehensive, individual assessment, all those detained in custody should have access to a choice of interventions appropriate to their need and to their specific (drug-related) situation.

9.Where good practice exists in related fields this should be adapted for use in harm reduction strategies with drug users in person.

10.There is a need to recognise that there must be a balance between security, control, prevention and treatment. Within such a balance, security and control can have a positive role in harm reduction strategies.

C. DRUG-FREE TREATMENT

1.Prisons should provide drug-free units for:
   a) treatment of drug users who want treatment.
   b) other prisoners who wish to be free from pressure to use drugs.

   Both types of unit are important and necessary. Prospects for the long term success of drug-free treatment can be improved if the prisoners who finish treatment are able to go to a drug-free unit.

2.Drug free treatment programmes should be holistic in nature. A combination of complementary programmes and treatment options should be provided. Different approaches for different sub-groups have to be available. Drug users who decline treatment need a harm reduction strategy.

3.Close co-operation between the professionals in prisons and external organisations is very important. Successful programmes will have groups in the local community who support the prison programme and who participate in relapse prevention and in continuity of treatment on release. Agreed treatment and administrative protocols should be developed.

4.Prisoners must be appropriately placed according to the risk they pose, and programmes delivered at the lowest level of security possible. However, serious offenders should not be denied access to a drug-free unit.

5.Staff education is an important prerequisite for implementation of treatment programmes. Staff attitudes, values and responsibilities must be developed so that they can facilitate the treatment process. Successful implementation of drug-free treatment requires a vision that is shared by staff and inmates.

6.All treatment programmes should be monitored and evaluated on a regular basis. This would help to ensure compliance with national guidelines, where they exist.

7.At both national and local level, public relations should be undertaken proactively to ensure that support is available for drug-free units.

8.Management should promote an overall view that sees the misuse of drugs in the context of the whole prison system. A multi-disciplinary approach is important. Multi-disciplinary teams, with internal and external participation, should be involved. This will help understanding of the issues by all staff and prisoners.

D. SUBSTITUTION TREATMENT

1.Substitution treatment includes both detoxification and maintenance.

2.Substitution treatment offers an opportunity to regularly engage with the prisoner, but it is not the whole, or the only solution to drug problems.

3.Although substitution is best used as one component of a comprehensive treatment regimen which includes psycho-social support, it may by itself provide prisoners with a period of stability that can help them to improve physical and mental health and social circumstances.

4.Individuals on maintenance in the community must have the option to continue to be maintained on entry to prison, and those receiving substitution treatment in prison must be able to continue with such treatment on release. Decisions on continuity of treatment should be taken in consultation with the treatment programme in which the prisoner participates outside prison.

5.A clear treatment contract must be drawn up between the prisoner and the programme.

6.A thorough, structured, ongoing assessment, leading to a cohesive treatment plan is necessary.

7.Adequate human resources and facilities for substitution treatment must be provided.

E. NEEDLE EXCHANGE PROGRAMMES

1.Prisons have the responsibility to provide prisoners with access to adequate infection preventing and health promoting measures.

2.Needle exchange is a sensitive area for Prison Services in many European countries. It is necessary to carry out a survey in prisons which are considering the introduction of needle exchange to find out how much injecting drug use exists within the prison prior to implementation.

3.Needle exchange programmes can be useful and integral parts of a general approach to drug and health services in prisons. They should be provided as part of a range of services that includes health promotion measures, counselling, drug-free treatment and substitution treatment.
4.To protect all parties participating in infection prevention and health promoting measures (such as needle exchange), legal ramifications must be clarified in advance of introduction of the measures. Legal issues need to be clarified especially concerning special groups, such as juveniles and inmates in substitution treatment. Clarification of these issues is the responsibility of the government department involved. The results of this clarification should be published.
5.The choice of distribution, either through machines or through personal contact, depends on the specific conditions within the respective prison settings. Continuity of availability of sterile syringes should be guaranteed, whether distributed by prison or community staff.
6.The successful implementation of needle exchange programmes in prison requires the establishment and the maintenance of acceptance among the prison staff and inmates, among political and legal authorities, professionals and the public at large
7.Participation in needle exchange programmes should be strictly confidential, so that the participant need not fear negative consequences during his or her remaining sentence.
8.The distribution facilities should be located in easily accessible areas.
9.Effective infection prevention can only be achieved if measures of instrumental prevention are supplemented by counselling and information. Mandatory education and voluntary training for inmates and prison staff at all participating levels should also be provided. The following issues are of particular relevance:
    a) basic knowledge about drug consumption and infection risks,
    b) means of transmission and infection prevention,
    c) safer use and safer sex,
    d) drug related first-aid.

F. PEER SUPPORT

1.Peer support is the process through which prisoners with drug problems receive information and support on issues of concern from people with similar experiences to their own. This process can be encouraged through peer education, which trains people with this experience to give accurate information and positive support to their peers.
2.Peer support can provide a wide range of services based on local and individual need (e.g. harm reduction, self-control, abstinence).
3.Peer support and peer education are efficient, cost-effective and harm minimizing strategies for health promotion.
4.Networking, information collection and evaluation in the framework of a European Union project on peer support is essential.
5.For a successful implementation of peer support, the advantages for all concerned should be clarified and staff should be informed and trained on drugs and infectious diseases as well as on the implementation of harm reduction strategies.
6.Peer educators with experience of the prison setting should be used for training prison staff by political institutions and administration. In addition, co-operation with external projects is necessary.
7.The training of both prison staff and peer leaders should be accredited, recognised and funded.
8.Professionals and the general public should be informed about the efficiency of peer support measures and the importance of a changed attitude and behaviour towards drugs.

The introduction of peer support demands a long-term continuous process of education, training and change in attitudes of the staff and also of the peers. The use of peer support is an expression of the necessity for change in the political attitude towards drugs.

A2 PRISON AND DRUGS 1998: YOUTH AND WOMEN – EUROPEAN RECOMMENDATIONS (THE EUROPEAN NETWORK OF DRUG AND HIV/AIDS SERVICES IN PRISON)

On 14-16 May 1998, 52 people from 11 European countries met in Marseilles to discuss the specific challenge presented by young people and women with drug problems in prison. This followed a Conference in Oldenburg in March 1998 which produced recommendations in separate areas of prison drug work (harm reduction, drug-free treatment, substitution treatment, needle exchange and peer support).

The participants at the Marseilles Conference created recommendations on drug services for young people and women in prison..

The recommendations will be presented at the 4th European Conference on Drug and HIV/AIDS Services in Prison (October 1999) for endorsement by the participants there. They will provide a resource for all those who work in the field of drug services in prison in Europe, and will be promoted through the activities of ENDHASP.

The draft recommendations from Marseilles have been split into three sections:
A. General - covers all prison drug services.
B. Young Prisoners - from the youth workshop.
C. Women in Prison - integrating recommendations from the two workshops on women.

In the course of consultation after the conference, it became clear that some countries, especially Sweden, would find it difficult to accept any recommendations that acknowledge the use of drugs in prison through efforts to minimise the harm done by such drug use (rather than on eradicating it). It should therefore be borne in mind that the principle on which these recommendations are based is that drug services in the prison system should be at least equivalent to those available outside prison in that country. The provision of prison drug services is therefore likely to follow different patterns in different countries. Nevertheless, we have much to learn from each other. Some of these lessons are encapsulated here.

A. GENERAL

1. Programmes should be evaluated in order to build on our knowledge of what works with young and female offenders. This evaluation should be based on a clear understanding of the aims of the programme; be it the welfare of the person, or the prevention of recidivism. Lessons should be learnt from existing research, such as that carried out in Sweden and Canada.
2. Efforts must be made to raise public awareness of:
   - what can prison reasonably do.
   - The relative costs and efficacy of imprisonment versus alternatives to custody – especially with women who have responsibility for child-care.
3. The credibility and efficacy of alternatives to custody must be increased.
4. A range of services should be available which takes into account the different needs of young and female prisoners. Competitive duplication of services should be avoided.
5. The family (or other support networks) should be involved in community sentences. The family should be educated about on what to expect and how to support the offender with drug problems.
6. Half way houses should be used for diversion from custody and for aftercare.

7. Experience of treatment programmes should be shared in order to develop a range of interventions for imprisoned drug users, and options for prescribing (including maintenance, reduction and detoxification). Options in custody should reflect those available in the community and should provide continuity of treatment.
8. In order to improve communications, there should be:
   - a national database or directory in each country of the drug services that are available in prisons and the community which is accessible to all prisons and community agencies.
   - information to offenders when they enter prison on services in that prison and the local area, on how to access them.
   - a web-site to facilitate better information exchange between prisons, doctors and community agencies in different countries.
   - improved communication between general practitioners and prison healthcare services in order to reduce inappropriate/dangerous prescribing and to guarantee continuity of care.
   - an inter-agency forum in each prison involving the judiciary, the police, community agencies, medical services, prisons, probation services.
9. Participation in treatment programmes should be on the basis of informed consent.

B. YOUNG PRISONERS

1. There should be greater coherence, continuity and consistency in drug services for young prisoners. Minimum standards for all prisons should be adapted for young offenders, with regard to the following issues:
   - the need for liaison with external youth and social services.
   - advice and information on prison and drugs which is aimed at young people, including basic information for recreational/experimental drug users as well as information for those with a more dependent pattern of use.
   - the need to provide positive role models for young prisoners through key working and mentoring.
   - peer support projects.
   - in depth and multi-disciplinary assessment.
2. These services should be provided in the context of effective partnership and co-ordination. There should be more openness and shared care, with one person or agency responsible for the package of services to each individual.
3. Innovative methods, such as peer support and creative workshops (e.g. rap, graffiti art) should be used to engage young prisoners in programmes which start from their level of understanding.
4. The family and other social support networks should be involved in the treatment and care of young offenders with drug problems.
5. Young prisoners should be able to take responsibility for their actions and for their treatment. This involves treating them with respect, using innovative methods in order to help them express what they need, and giving them opportunities for reparation and restitution for the harm they have caused.
6. There should be training for all those working with young prisoners, and especially for prison officers in order to raise awareness of the specific needs of young people. This training should include:
   - psycho-social development.
   - the nature of adolescence.
   - vocational and educational needs.
   - drug issues.
   - the involvement of external youth workers.
   - information on social services for young people.
   - strategies on bullying and intimidation.

7. There should be specific responses to the needs of young female prisoners, and to the needs of young prisoners from diverse cultural backgrounds.

C. WOMEN IN PRISON

1. There should be better and earlier assessment of female offenders before they reach prison in order to understand their individual needs. This should include specific information about any drug use and its underlying causes, which should inform the use of treatment and medication.
2. A care plan should be made and implemented, using a multi-disciplinary approach, beginning at the entry to prison and continuing throughout the period of detention. The plan should recognise the specific needs of women, highlighting the following areas, as identified in assessment:
   - education, training and employment.
   - histories of abuse.
   - cultural differences.
   - health care.
   - child care.
   - the reduction of offending.

   Such plans should be reviewed regularly.

   Training should be provided:
   - specifically for criminal justice workers (especially prison staff) in working with female drug users.
   - on drug use being the symptom of wide range of underlying problems, so that a holistic approach is necessary.
   - for non-specialist staff to guide them in what is realistic in measuring success.
3. Agencies that will work with women prior to their entry into the criminal justice system should be trained about drug issues and specifically how these differ for women.
4. Cross gender staffing should be developed in order to provide positive contact between the sexes.
5. Equality of opportunity in the provision of educational and employment should be improved.
6. Care should be taken in working with women who are mothers to ensure that their involvement in parenting skills training, and in caring for their children is appropriate to their situation and to their own wishes.

A3 CONCLUSIONS OF 'THE EUROPEAN PEER SUPPORT PROJECT PHASE 3: RISK REDUCTION ACTIVITIES IN PRISON' (TRIMBOS INSTITUTE UTRECHT/THE NETHERLANDS; CARL VON OSSIETZKY UNIVERSITY OLDENBURG/GERMANY, JANUARY 1998)

In the face of the increasing number of drug using inmates in European prisons and the dangers of drug related harm and communicable diseases such as HIV/AIDS and Hepatitis, it is clear that implementation of risk reduction strategies into prisons is urgently needed. This implementation broadens the range of measures which are currently used only in drug-free treatment and methadone detoxification or for a limited number of penitentiaries, in maintenance programmes.

It becomes also clear, however, that this approach of risk reduction and the integration of inmates and staff members in seminars is relatively new to the prison system and is often perceived as threatening to the traditional abstinence oriented drug policy. The aim of risk reduction activities in prison is to achieve a level-headed approach to health care matters of drug addicted inmates and the health risks of the personnel.

Therefore the seminars must be prepared very carefully with very clear arrangements between prison administration and the drug service which is going to carry out risk reduction activities in the prison. The specific conditions of the prison should be accepted, that means the structure of decision-making, communication and co-operation has to be acknowledged. It is for instance inevitable to obtain permission from the prison governor before anything else. It is very helpful to take into account the internal infrastructure of the prison and to co-operate with the persons that are relevant for realising risk reduction strategies such as drug counsellors or doctors.

Peer support initiatives must be aware of and take into account specific conditions of the targeted prison. There might be considerable differences between different countries and regions. Every prison has its own policy, its own population of inmates and its own way of communication/co-operation with external drug and AIDS services. Careful preparation is necessary to target the specific needs of the inmates as well as the staff members. The planning of the peer support activities should be adapted to these conditions. The material that is used or developed in the peer support activities should also reflect the specific prison conditions.

All the European Peer Support Prison Project (EPSPP) seminars organised in prisons were different from each other: There were different target groups (inmates, staff members, peer-leaders) and different organisations carrying out the risk reduction and peer support activities (university, drug services, staff members, etc.). But the basic concept of peer support remained the same: the work focussed on the specific needs of the target groups and on integration of the skills and the experience of people involved when addressing risk reduction strategy in prison. Through using the knowledge and experience and skills of drug users, the basis for peer support within a self organisation is broadened. The information brochure for new prisoners, which was made by the Italian group of prisoners, is one example how prisoners can be integrated. The material which was developed in other prisons may serve as a starting point for further training activities and information exchange.

The general outline of the seminars developed can be used in future seminars either by external groups or internal professionals (like drug counsellors). Like in one German prison (the men's prison in Groß Hesepe) the staff training courses were continued by the local AIDS-Hilfe. After the third phase of the

EPSPP in prisons was over, they adapted the concept and carried out a series of training courses for the staff members. The involvement of external services is to a certain extent a guarantee for continuity.

The venue of the training courses for staff members seems to be of great importance for the atmosphere and the readiness to talk. It certainly makes a big difference whether the seminars are carried out within the prison walls or outside the prison in training centres. Both options are possible. Carrying out seminars for the staff within the prison has the advantage that the number of participants will be higher, because the threshold for participation is low. Choosing a venue outside prison, on the other hand, has the advantage that it might be easier for the participants to address controversial topics more frankly.

Regarding drug using prisoners one can either chose to work in a group or on a individual basis. Some prisons do not permit group work because it is regarded as threatening to security measures. Other prisons will allow both working in groups or with individual prisoners. The contents and methods applied have to be adjusted accordingly. While with individuals it is to a greater extent possible to transfer information which expands the knowledge of the prisoner, the communication aspect is more emphasised within the context of a group. For the safer sex courses it might also be important to have gender specific groups and trainers. The experiences in both German prisons show that it is more authentic and credible, when there is a homogeneous trainer-prisoner-relationship.

These modules could be training parts on different issues could focus entail training courses on a wide range of issues. Different forms of training courses have been mentioned such as:

- training of prison staff only
- training of prison staff and imprisoned drug users
- training of prison staff and non-imprisoned drug users
- training of prison staff, drug service staff and drug users

Combining the target groups can be quite powerful with regard to exchange of information, change of attitude, etc. Exercises from the European Peer Support Manual have proved to be useful in this respect. Here also an inventory could be fruitful.

A. training of drug users

- training courses for groups of drug users
- training of individual drug users (as peer tutors)

Exercises could focus on the expertise of drug users how to avoid risks.
An issue to be discussed is the question whether to differentiate the target group (men -women, young - old, 'aboriginals' and 'foreigners', etc.

B. Training of non-imprisoned drug users
Drug users outside prison could be trained with support from already existing self help groups. Again exercises could focus on the expertise of drug users how to avoid risks.

C. Training of drug service staff
Staff of drug services can play an important role in supporting risk reduction activities and peer support in prisons. For the training of drug service staff goes the same as has been mentioned for the training of prison staff.

A4 EUROPEAN GUIDELINES ON HIV/AIDS AND HEPATITIS IN PRISON (MILAN, MAY 1999, LAUNCHED BY THE EUROPEAN NETWORK ON HIV AND HEPATITIS PREVENTION IN PRISON)

A General Recommendations

1. Prevention of HIV and Hepatitis in prison should be considered as a global and frontline public health issue. In a context of an increasing drug consumption in most of the communities and socio-economic inequalities, prison populations have increased dramatically over the last two decades. Priority should be given to decrease the number of prisoners in European settings and to find alternative solutions to imprisonment, especially for drug users and people with serious communicable or chronicle diseases.
2. Prisoners should be fully considered as citizens and, consequently, should benefit, on a voluntary basis, from the same health care and prevention measures as those available in their local communities.
3. There should be equivalence of health care inside and outside prisons, and experience from the European region suggests that this is better achieved if the responsibility for prisoners´ health lies with the Ministry of Health.
4. There should be continuity of treatment for prisoners entering and leaving prisons involving co-operation between prisons and external agencies. Prisons have to be regarded as an integral part of society, closely linked to other social systems. Health care in prisons should be conceived as closely linked to community health care in order to:
   - ensure that preventive measures are fully available in prisons, and
   - provide continuity of care for prisoners and ex-prisoners.

B Health care education and information for prisoners

1. On entry into prison or remand, all prisoners should receive information and education about the nature and transmission routes of sexual and blood-borne virus infections in and also outside prison, and the methods and precautions that are available to prevent their spread both inside and outside prison.
2. Prisoners should be able to have questions answered by a knowledgeable health-care worker. Information about the availability of counselling, viral testing and immunisation should be given at this time.

C Voluntary HIV Testing and Prevention

1. Voluntary HIV testing and counselling should be offered and easily available on a confidential basis to all prisoners throughout their sentences, free of charge, and with qualified pre- and post-test counselling. Counselling is necessary and important also in case of negative test results.
2. Trained health care personnel should deliver confidential HIV results, whatever the status is. Under no circumstances, he/she should be obliged to inform administrative authorities without the prisoners´ written consent.
3. Medical treatment for bloodborne viruses should be given by the same standards as outside prison; neither segregation, nor any discrimination against HIV and/or Hepatitis positive prisoners is acceptable.
4. Basic HIV education by qualified staff should be given regularly to all prisoners, (also to those who

do not understand the respective national language) as well as to prison staff.

D Drug related harm reduction

1. It has to be acknowledged that there will always be prisoners who will get hold of drugs inside prison and for that reason, the possibility for safe injection should be available.
2. Some European pilot projects clearly showed the feasibility and efficacy of needle-exchange-programmes in prison. National programmes should promote pilot projects in voluntary prisons.
3. For some prisoners, prisons represent an opportunity to address their drug dependence. Therefore efforts should be made to provide:
   a)treatment opportunities for drug users who want to reduce their drug dependence,
   b)voluntary drug testing units for prisoners who have become drug free and want to maintain a drug free life style,
   c)assistance for other prisoners who wish to be free from pressure to use drugs.
4. Drug free treatment programmes should be holistic in nature. A combination of complementary programmes and treatment options should be provided. Different approaches for different sub-groups have to be available. Drug users who decline treatment need a harm reduction strategy. As they could be an opportunity to some drug abusers, drug free unit programmes should be evaluated appropriately.
5. Positive reinforcement for being drug free should be used, e.g. increased furlough or visits, or shortening of time served in exchange for documented freedom from drugs. However these proposals should be evaluated before being disseminated.
6. Mandatory drug testing, which has been shown inefficient both in economical and medical perspectives, should not be a part of the drug policy inside prison.
7. For drug users who want to stop drugs, treatment inside or outside prison should be widely promoted. To achieve this goal, randomised studies should be carried out in order to prioritise efficient methods and programmes.
8. Although treatment with methadone and buprenorphine have been shown as a benefit for many opiate consumers, there is a need to evaluate the efficiency of those treatments with an appropriate methodology. Substitution treatment includes both detoxification and maintenance. Substitution treatments offer an opportunity to regularly discuss health and drug-related topics with the prisoner, but it has to be pointed out that it is not the whole, or only, solution to drug problems.

E Condom Availability

1. From the experience of some European countries, easy access to condoms and water based lubricants should be promoted. The studies of the European Network on HIV and Hepatitis Prevention and others have shown that homo- and heterosexual intercourse in prisons occurs, for that reason condoms should also be available (anonymous and free of charge) in all prisons. Experience from several European Countries shows that this policy is effective, despite potential security problems and contributes significantly to STD prevention in prison.
2. Rooms in prisons where conjugal visits are permitted or where sexual intercourse can occur in good humane and safe conditions should be promoted. Furthermore such facilities could reinforce social and emotional links of prisoners with their partners and families. These programmes deserve to be carefully evaluated before their generalisation.

F HIV, Hepatitis and Migrants

1. The high proportion of migrants in the prison population in most of the European countries (compared to the general population) shows clearly the need for improvement of groups-specific information for ethnic minorities and foreigners. Account should be taken to the different backgrounds and different individual native languages.
2. The prison administrations have to consider the need for interpreters in the medical services. All prevention efforts should be adopted as far as possible to the specific needs of the respective migrant populations.

G Hepatitis Screening and Prevention

1. Because of the high prevalence of these infections among persons who enter prisons, screening of viral Hepatitis C should be offered on a voluntary basis to all prisoners at-risk, especially current and former IDU. Those who are positive should be evaluated for treatment, in line with the local policy in the community.
2. Since there are now good vaccines for Hepatitis B, immunisation against Hepatitis B should be offered at admission to all prisoners, regardless of the length of their sentence. Good counselling should be given to prisoners, especially to avoid confounding messages between HIV and viral Hepatitis.

Short Hepatitis B vaccination schedules may achieve higher compliance and should be evaluated in prison.

H Staff Health Education

1. Prison staff need training and regular updating on all aspect of HIV, Hepatitis and drug abuse - medical, psychological and social - in order to feel secure for themselves and also be able to give prisoners appropriate guidance and support.
2. Prison staff should always be aware of, and apply general protection measures against virus transmission. It is not important to know the sero-status of the prisoners, and all must be equally handled, i.e. as if they were positive, mainly due to the window period, and in order to avoid discrimination.
3. There must be regular opportunities for exchange of information and best practice between prisons and outside agencies at all levels.
4. Prison staff also needs to be vaccinated, at least against Hepatitis B, which is a potential risk for them when searching pockets and bags.
5. Prison staff need exact plans how to handle any situations of emergency.
6. Protocols for HIV/Hepatitis outbreaks should be prepared.
7. In their role as health care providers, prison staff should be fully informed about post-exposure prevention measures, in line with the local policy.

I Pre-Release Prevention and Furlough

1. Condoms and prevention kits should be offered before furlough.
2. Prisoners with drug problems will benefit from tailored prevention pre-release programmes, especially information about prevention of overdoses which have been shown as frequent cause of early deaths among released drug abusers.

3. Such programmes could reinforce the medical and social treatments, which are offered within prisons. The prison should make a link on the prisoners´ behalf, with the community drug team to enable continuity of treatment and care in the community.

J Epidemiological surveillance

1. Some valid system for epidemiological surveillance should be performed at regular intervals in European prisons and integrated in the current national epidemiological surveillance system. The anonymous linked saliva/questionnaire testing worked out by the European Network on HIV and hepatitis prevention in prison is a valid and reliable approach to monitor the spread of HIV. It is important to sample prisons of different types and in different regions, since local variations can be considerable.

Appropriate procedures should be worked out to investigate outbreaks of HIV and Hepatitis and to report such cases.

A5 RECOMMENDATION NO. R (93)6 OF THE COMMITTEE OF MINISTERS TO MEMBER STATES CONCERNING PRISON AND CRIMINOLOGICAL ASPECTS OF THE CONTROL OF TRANSMISSIBLE DISEASES INCLUDING AIDS AND RELATED HEALTH PROBLEMS IN PRISON64

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe, Considering that it is in the interests of the member States of the Council of Europe to achieve greater unity between its members and that one way of pursuing this objective is joint action both in the field of health care in prisons and in the field of crime policy;

Aware of the extent of the challenge presented to prison authorities by the responsibility for the development of preventive measures and the medical, psychological and social care of HIV-infected prisoners;
Convinced of the need to establish a European strategy to combat HIV infection in prisons;

Taking into account the 1987 statement of the consultation on the prevention and control of AIDS in prisons, of the special programme on AIDS of the World Health Organization;

Recalling its Recommendation No. R (87) 25 concerning a common European public health policy to fight the acquired immunodeficiency syndrome (AIDS);

Recalling the conclusions adopted by the 8th Conference of Directors of Prison Administrations (Strasbourg, 2 - 5 June 1987) on communicable diseases in prisons with special reference to AIDS;

Recalling the conclusions adopted by the 16th Conference of European Ministers of Justice (Lisbon, 21 - 23 June 1988) on the criminal law and criminological questions raised by the propagation of infectious diseases, including AIDS;

Welcoming Recommendation 1080 (1988) of the Parliamentary Assembly of the Council of Europe on a co-ordinated European health policy to prevent the spread of AIDS in prisons;

Referring to its Recommendation No. R (89) 14 on the ethical issues of HIV infection in the health care and social settings;

Aware that respect for the fundamental rights of prisoners, in particular the right to health care, entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general;

Referring in this connection to the Convention for the Protection of Human Rights and Fundamental Freedoms and the European Social Charter;

Referring to its Recommendation No. R (87) 3 on the European Prison Rules which help to guarantee minimum standards of humanity and dignity in prisons;

Considering that in order to comply with ethical requirements and to be effective, preventive and health

[64] Adopted by the Committee of Ministers on 18 October 1993 at the 500th meeting of the Ministers' Deputies

care measures should be based on the voluntary co-operation of the prison population.

RECOMMENDS that the governments of member States:

- see to it that the principles and provisions set out in the Appendix to the Recommendation and prepared in the light of present-day knowledge are put into practice in national and regional prison health policies designed to combat HIV infection and other transmissible diseases;
- ensure the widest possible dissemination of this Recommendation, paying special attention to all individuals and bodies responsible for implementing health policy in prisons, and also to all law officers and bodies concerned with crime policy and related criminological aspects of the control of transmissible diseases.

Appendix to Recommendation No. R (93)6

I. PRISON ASPECTS

A. General principles

1. There is an urgent need to draw up, in each State, a coherent policy for combating HIV/AIDS in prison. Such a policy should be developed in close collaboration with national health authorities and be incorporated in a wider policy for combating transmissible diseases in prisons. Ways and means of preventing HIV/AIDS in prisons should be fostered. Health education and information for all inmates and personnel should be an integral part of prison policies.
2. The systematic medical examination carried out on entry into prison should include measures to detect intercurrent diseases, including treatable infectious diseases, in particular of tuberculosis. The examination also gives the opportunity to provide health education and to give prisoners a greater sense of responsibility for their own health.
3. Voluntary testing for HIV/AIDS infection together with counselling before and after the test should be made available. Health staff should, under the responsibility of a doctor, explain to prison inmates the consequences of test results prior to undergoing such tests, and inform them of the results, in full confidentiality, unless he/she declines to receive such information. In the present state of knowledge, compulsory testing of prisoners should be prohibited since it would be ineffective and discriminatory and therefore unethical.
4. At each stage of HIV/AIDS infection, prisoners should be offered the same medical and psychosocial treatment as that given to other members of the community. In general, they should have access to health services which are equivalent to those of the community at large. Co-operation with national or regional health systems facilitates the medical care of seropositive prisoners and prisoners suffering from AIDS as well as their medical follow-up on entry and after release.
5. Medical care, psychological support and social services should be organised for seropositive prisoners to facilitate their integration after release.
6. A special effort should be made to disseminate information among both prison staff and prisoners to ensure that they are aware of modes of HIV transmission, as well as the rules of hygiene to be observed and precautions to be taken to reduce the risks of contamination during detention and after release. Health and prison authorities should provide information and where appropriate individual counselling on risk behaviours. Information should be made available to prisoners in a language they can understand and if necessary taking into account their cultural background.
7. In the interest of preventing HIV infection, prison and health authorities should make condoms available to prisoners during their period of detention and prior to their provisional or final release.

Each State should be free to select the most appropriate channel for this purpose: medical service, sale in canteens or any other arrangements suited to current attitudes, the type of prison population concerned and the prison establishment's mode of operation.

8. Information about the health of prisoners is confidential. The doctor may only provide such information to the other members of the medical team, and exceptionally to the prison management, as is strictly necessary for the treatment and care of the prisoner or to examine the health of the prisoners and staff, with due regard to medical ethics and legal provisions. Normally this should take place with the consent of the person concerned. Disclosure of information should follow the same principles as those applied in the general community. HIV/AIDS serological status is not generally considered necessary information.
9. As segregation and isolation and restrictions on occupation, sports and recreation are not considered necessary for seropositive people in the community, the same attitude must be adopted towards seropositive prisoners. When prisoners try to sexually assault other prisoners or more generally try to harm other prisoners or staff, disciplinary measures or solitary confinement may be justified independently of the HIV status.
10. Sanitary facilities conforming to standards in the community should be available to prisoners in all sections of a prison.
11. All means necessary to allow them to observe the rules of hygiene should be made available to prison staff and prisoners.
12. Seropositive prisoners should receive medical follow-up and counselling during their period of detention and particularly when they are notified of test results. Medical services in prison establishments should ensure that medical and psychological follow-up of prisoners is available after their release and encourage them to use these services.
13. HIV-infected prisoners should not be excluded from measures such as placement in semi-liberty hostels or centres or any other types of open or low-security prison.
14. Prisoners with terminal HIV disease should be granted early release, as far as possible, and given proper treatment outside the prison.
15. Adequate financial and human resources should be made available within the prison health system to meet not only the problems of transmissible diseases and HIV/AIDS but also all health problems affecting prisoners.
16. Persons deprived of their liberty may not undergo medical research unless it is expected to produce a direct and significant benefit to their health. Ethical principles concerning research on human subjects must be strictly applied, particularly in relation to informed consent and confidentiality. All research studies carried out in prisons should be subject to approval by an ethical review committee or to an alternative procedure guaranteeing these principles. Research on the prevention, treatment and management of transmissible diseases in prison populations should be encouraged provided that such research yields information not available from studies in the community. Prisoners should have the same access to clinical trials of treatments for all HIV/AIDS-related diseases as persons living in the community. Epidemiological HIV/AIDS monitoring including anonymous, non-correlated screening could be considered only if such methods are used in the general population and if their application to prison populations appears likely to yield results useful to prisoners themselves. Prisoners should be informed in due time about the existence of any epidemiological studies carried out in the prison where they are detained. Publication and communication of results of research studies must ensure absolute confidentiality about the identity of prisoners who have participated in such studies.

B. Special measures

17. The prison authorities should adopt, as far as possible, measures to prevent the illicit introduction of drugs and injection material into prisons. However, such measures should not prejudice the trend towards the closer integration of prisons into the economic and social environment.
18. Prevention requires the introduction and development of health education programmes in order to reduce risks, including the provision of information on the need to disinfect injection equipment or use it only once. A disinfectant should be made available to prisoners not only to protect them against transmissible diseases but also to enable them to observe the rules of hygiene.
19. Health care and social programmes should be developed with a view to preparing drug-using prisoners for release and to adapting early release arrangements, conditional on following appropriate treatment (hostel, after-care centre, hospital, out-patient service, therapeutic community).
20. Non-custodial measures should be more widely used by courts or other competent authorities in order to encourage drug addicts to seek treatment in health or social institutions. Drug addicts should be encouraged to follow such treatment programmes.
21. Prisoners and their families, spouses or partners who are allowed unsupervised visits must be offered information, counselling and support in connection with HIV/AIDS. Preventive and contraceptive measures should be made available to prisoners and their partners in accordance with the law in force in the community.
22. Health education programmes should be adapted to the specific needs of women prisoners. Pregnant seropositive prisoners must receive care and assistance equivalent to those given to women outside the prison. They must have as much information as possible on the risks of infection of the unborn child and, if national legislation so provides, have the option of voluntary termination of pregnancy. A seropositive child born to a woman prisoner should remain with the mother, if she so desires, in conformity with prison regulations. The child should have access to appropriate specialist medical services.
23. Health education programmes should be adapted to the needs of prisoners, particularly young prisoners, to foster attitudes and behaviour conducive to the avoidance of transmissible diseases including HIV/AIDS.
24. Foreign prisoners suffering from HIV/AIDS should be given the same information, counselling and health care as other inmates.
25. HIV/AIDS infection should not prevent a prisoner from being transferred on the basis of a bilateral agreement or of the Council of Europe Convention on the Transfer of Sentenced Persons. The medical report on a sentenced person transferred to his/her country of origin should be sent directly by the prison medical services in the sentencing State to the prison medical service in the enforcing State, since the report is protected by medical confidentiality.
26. Arrangements for the deportation of foreign HIV/AIDS-infected prisoners may be postponed for humanitarian reasons if the prisoners are seriously or terminally ill.

II. CRIMINOLOGICAL ASPECTS

27. The priority in controlling transmissible diseases, including HIV/AIDS, is the introduction of preventive measures and information designed to develop awareness and a sense of responsibility among the public.
28. Sanctions relating to the transmission of transmissible diseases and HIV/AIDS should be envisaged within the context of existing offences, and the institution of criminal proceedings should be considered as a last resort.
29. Such criminal proceedings should be aimed at sanctioning those who, in spite of information and

awareness-building campaigns to prevent the spread of HIV/AIDS, have nevertheless endangered the lives, physical integrity or health of others.

30. Health care officials or practitioners who have violated norms and practices designed to prevent the spread of transmissible diseases or who do not fulfil their duty to treat individuals infected by HIV/AIDS should be liable to disciplinary sanctions and, if appropriate, be subject to the criminal laws in force.

A6 COUNCIL OF EUROPE, COMMITTEE OF MINISTERS, RECOMMENDATION NO. R (98) 71 OF THE COMMITTEE OF MINISTERS TO MEMBER STATES CONCERNING THE ETHICAL AND ORGANISATIONAL ASPECTS OF HEALTH CARE IN PRISON[65]

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,
Considering that medical practice in the community and in the prison context should be guided by the same ethical principles;
Aware that the respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general;

Recognising that the medical practitioner in prison often faces difficult problems which stem from conflicting expectations from the prison administration and prisoners, the consequences of which require that the practitioner should adhere to very strict ethical guidelines;

Considering that it is in the interests of the prison doctor, the other health care staff, the inmates and the prison administration to proceed on a clear vision of the right to health care in prison and the specific role of the prison doctor and the other health care staff;

Considering that specific problem situations in prisons such as overcrowding, infectious diseases, drug addiction, mental disturbance, violence, cellular confinement or body searches require sound ethical principles in the conduct of medical practice;

Bearing in mind the European Convention on Human Rights, the European Social Charter and the Convention on Human Rights and Biomedicine;

Bearing in mind the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, and the recommendations on health care service in prisons summarised in the 3rd general report on the activities of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment;

Referring to its Recommendation No. R (87) 3 on the European Prison Rules which help to guarantee minimum standards of humanity and dignity in prisons;

Recalling Recommendation No. R (90) 3 on medical research on human beings and Recommendation No. R (93) 6 concerning prison and criminological aspects of the control of transmissible diseases including Aids and related health problems in prison, as well as the 1993 WHO guidelines on HIV infection and Aids in prison;

Mindful of Recommendations 1235 (1994) on psychiatry and human rights and 1257 (1995) on the conditions of detention in Council of Europe member states, prepared by the Parliamentary Assembly of the Council of Europe;

Referring to the Principles of Medical Ethics for the Protection of Detained Persons and Prisoners against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by United

[65] Adopted by the Committee of Ministers on 8 April 1998 at the 627th meeting of the Ministers' Deputies

Nations General Assembly in 1982;

Referring to the specific declarations of the World Medical Association (WMA) concerning medical ethics, in particular the Declaration of Tokyo (1975), the Declaration of Malta on hunger strikers (1991) and the Statement on body searches of prisoners (1993);

Taking note of recent reforms in structure, organisation and regulation of prison health care services in several member states, in particular in connection with reforms of their health care systems;

Taking into account the different administrative structures of member states which require the implementation of recommendations both at federal and state levels,

Recommends that the governments of member states:

- take into account, when reviewing their legislation and in their practice in the area of health care provision in prison, the principles and recommendations set out in the appendix to this recommendation;
- ensure the widest possible dissemination of the recommendation and its explanatory memorandum, paying special attention to all individuals and bodies responsible for the organisation and provision of preventive treatment and health care in prison.

Appendix to Recommendation No. R (98) 7

I. Main characteristics of the right to health in prison

A. Access to a doctor

1. When entering prison and later on while in custody, prisoners should be able at any time to have access to a doctor or a fully qualified nurse, irrespective of their detention regime and without undue delay, if required by their state of health. All detainees should benefit from appropriate medical examinations on admission. Special emphasis should be put on the screening of mental disorders, of psychological adaptation to prison, of withdrawal symptoms resulting from use of drugs, medication or alcohol, and of contagious and chronic conditions.
2. In order to satisfy the health requirements of the inmates, doctors and qualified nurses should be available on a full-time basis in the large penal institutions, depending on the number and the turnover of inmates and their average state of health.
3. A prison's health care service should at least be able to provide out-patient consultations and emergency treatment. When the state of health of the inmates requires treatment which cannot be guaranteed in prison, everything possible should be done to ensure that treatment is given, in all security in health establishments outside the prison .
4. Prisoners should have access to a doctor, when necessary, at any time during the day and the night. Someone competent to provide first aid should always be present on the prison premises. In case of serious emergencies, the doctor, a member of the nursing staff and the prison management should be warned; active participation and commitment of the custodial staff is essential.
5. An access to psychiatric consultation and counselling should be secured. There should be a psychiatric team in larger penal institutions. If this is not available as in the smaller establishments, consultations should be assured by a psychiatrist, practising in hospital or in private.
6. The services of a qualified dental surgeon should be available to every prisoner.

7. The prison administration should make arrangements for ensuring contacts and co-operation with local public and private health institutions. Since it is not easy to provide appropriate treatment in prison for certain inmates addicted to drugs, alcohol or medication, external consultants belonging to the system providing specialist assistance to addicts in the general community should be called on for counselling and even care purposes.
8. Where appropriate, specific services should be provided to female prisoners. Pregnant inmates should be medically monitored and should be able to deliver in an external hospital service most appropriate to their condition.
9. In being escorted to hospital the patient should be accompanied by medical or nursing staff, as required.

B. Equivalence of care

10. Health policy in custody should be integrated into, and compatible with, national health policy. A prison health care service should be able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public. Prison doctors should be able to call upon specialists. If a second opinion is required, it is the duty of the service to arrange it.
11. The prison health care service should have a sufficient number of qualified medical, nursing and technical staff, as well as appropriate premises, installations and equipment of a quality comparable, if not identical, to those which exist in the outside environment.
12. The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, health care and organisation of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should co-operate in implementing an integrated health policy in prison.

C. Patient's consent and confidentiality

13. Medical confidentiality should be guaranteed and respected with the same rigour as in the population as a whole.
14. Unless inmates suffer from any illness which renders them incapable of understanding the nature of their condition, they should always be entitled to give the doctor their informed consent before any physical examination of their person or their body products can be undertaken, except in cases provided for by law. The reasons for each examination should be clearly explained to, and understood by, the inmates. The indication for any medication should be explained to the inmates, together with any possible side effects likely to be experienced by them.
15. Informed consent should be obtained in the case of mentally ill patients as well as in situations when medical duties and security requirements may not coincide, for example refusal of treatment or refusal of food.
16. Any derogation from the principle of freedom of consent should be based upon law and be guided by the same principles which are applicable to the population as a whole.
17. Remand prisoners should be entitled to ask for a consultation with their own doctor or another outside doctor at their own expense. Sentenced prisoners may seek a second medical opinion and the prison doctor should give this proposition sympathetic consideration. However, any decision as to the merits of this request is ultimately his responsibility.
18. All transfers to other prisons should be accompanied by full medical records. The records should be transferred under conditions ensuring their confidentiality. Prisoners should be informed that their medical record will be transferred. They should be entitled to object to the transfer, in accordance

with national legislation. All released prisoners should be given relevant written information concerning their health for the benefit of their family doctor.

D. Professional independence

19. Doctors who work in prison should provide the individual inmate with the same standards of health care as are being delivered to patients in the community. The health needs of the inmate should always be the primary concern of the doctor.
20. Clinical decisions and any other assessments regarding the health of detained persons should be governed only by medical criteria. Health care personnel should operate with complete independence within the bounds of their qualifications and competence.
21. Nurses and other members of the health care staff should perform their tasks under the direct responsibility of the senior doctor, who should not delegate to paramedical personnel tasks other than those authorised by law and by deontological codes. The quality of the medical and nursing services should be assessed by a qualified health authority.
22. The remuneration of medical staff should not be lower than that which would be used in other sectors of public health.

II. The specific role of the prison doctor and other health care staff in the context of the prison environment

A. General requirements

23. The role of the prison doctor is firstly to give appropriate medical care and advice to all the prisoners for whom he or she is clinically responsible.
24. It should also imply advising the prison management on matters concerned with nutrition or the environment within which the prisoners are required to live, as well as in respect of hygiene and sanitation.
25. Health care staff should be able to provide health information to the prison management and custodial staff as well as appropriate health training, as necessary.

B. Information, prevention and education for health

26. On admission to prison, each person should receive information on rights and obligations, the internal regulations of the establishment as well as guidelines as to how and where to get help and advice. This information should be understood by each inmate. Special instruction should be given to the illiterate.
27. A health education programme should be developed in all prison establishments. Both inmates and prison administrators should receive a basic health promotion information package, targeted towards health care for persons in custody.
28. Emphasis should be put on explaining the advantages of voluntary and anonymous screening for transmissible diseases and the possible negative consequences of hepatitis, sexually transmitted diseases, tuberculosis or infection with HIV. Those who undergo a test must benefit from follow-up medical consultation.
29. The health education programme should aim at encouraging the development of healthy lifestyles and enabling inmates to make appropriate decisions in respect of their own health and that of their families, preserving and protecting individual integrity, diminishing risks of dependency and recidivism. This approach should motivate inmates to participate in health programmes in which they are taught in a coherent manner the behaviour and strategies for minimising risks to their health.

C. Particular forms of pathology and preventive health care in prison

30. Any signs of violence observed when prisoners are medically screened on their admission to a prison establishment should be fully recorded by the doctor, together with any relevant statements by the prisoner and the doctor's conclusions. This information should also be made available to the prison administration with the consent of the prisoner.
31. Any information on cases of violence against inmates, occasioned in the course of detention, should be forwarded to the relevant authorities. As a rule, such action should only be undertaken with the consent of the inmates concerned.
32. In certain exceptional cases, and in any event in strict compliance with the rules of professional ethics, the informed consent of the prisoner need not be regarded as essential, in particular, if the doctor considers that he or she has an overriding responsibility both to the patient and to the rest of the prison community to report a serious incident that presents a real danger. The health care service should collect, if appropriate, periodic statistical data concerning injuries observed, with a view to communicating them to the prison management and the ministries concerned, in accordance with national legislation on data protection.
33. Appropriate health training for members of the custodial staff should be provided with a view to enabling them to report physical and mental health problems which they might detect in the prison population.

D. The professional training of prison health care staff

34. Prison doctors should be well versed in both general medical and psychiatric disorders. Their training should comprise the acquisition of initial theoretical knowledge, an understanding of the prison environment and its effects on medical practice in prison, an assessment of their skills, and a traineeship under the supervision of a more senior colleague. They should also be provided with regular in-service training.
35. Appropriate training should also be provided to other health care staff and should include knowledge about the functioning of prisons and relevant prison regulations.

III. The organisation of health care in prison with specific reference to the management of certain common problems

A. Transmitted diseases, in particular: HIV infection and Aids, Tuberculosis, Hepatitis

36. In order to prevent sexually transmitted infections in prison adequate prophylactic measures should be taken.
37. HIV tests should be performed only with the consent of the inmates, on an anonymous basis and in accordance with existing legislation. Thorough counselling should be provided before and after the test.
38. The isolation of a patient with an infectious condition is only justified if such a measure would also be taken outside the prison environment for the same medical reasons.
39. No form of segregation should be envisaged in respect of persons who are HIV antibody positive, subject to the provisions contained in paragraph 40.
40. Those who become seriously ill with Aids-related illnesses should be treated within the prison health care department, without necessarily resorting to total isolation. Patients, who need to be protected from the infectious illnesses transmitted by other patients, should be isolated only if such a measure is necessary for their own sake to prevent them acquiring intercurrent infections, particularly in those cases where their immune system is seriously impaired.
41. If cases of tuberculosis are detected, all necessary measures should be applied to prevent the

propagation of this infection, in accordance with relevant legislation in this area. Therapeutic intervention should be of a standard equal to that outside of prison.

42. Because it is the only effective method of preventing the spread of hepatitis B, vaccination against hepatitis B should be offered to inmates and staff. Information and appropriate prevention facilities should be made available in view of the fact that hepatitis B and C are transmitted mainly by the intravenous use of drugs together with seminal and blood contamination.

B. Addiction to drugs, alcohol and medication: management of pharmacy and distribution of medication

43. The care of prisoners with alcohol and drug-related problems needs to be developed further, taking into account in particular the services offered for drug addicts, as recommended by the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs ("Pompidou Group"). Therefore, it is necessary to offer sufficient training to medical and prison personnel, and to improve co-operation with external counselling services, in order to ensure continuing follow-up therapy on discharge to the community.
44. The prison doctor should encourage prisoners to take advantage of the system of social or psychotherapeutic assistance in order to prevent the risks of abuse of drugs, medication and alcohol.
45. The treatment of the withdrawal symptoms of abuse of drugs, alcohol or medication in prison should be conducted along the same lines as in the community.
46. If prisoners undergo a withdrawal cure, the doctor should encourage them, both while still in prison and after their release, to take all the necessary steps to avoid a relapse into addiction.
47. Detained persons should be able to consult a specialised internal or external counsellor who would give them the necessary support both while they are serving their sentence and during their care after release. Such counsellors should also be able to contribute to the in-service training of custodial staff.
48. Where appropriate, prisoners should be allowed to carry their prescribed medication. However, medication which is dangerous if taken as an overdose should be withheld and issued to them on an individual dose-by-dose basis.
49. In consultation with the competent pharmaceutical adviser, the prison doctor should prepare as necessary a comprehensive list of medicines and drugs usually prescribed in the medical service. A medical prescription should remain the exclusive responsibility of the medical profession, and medicines should be distributed by authorised personnel only.

C. Persons unsuited to continued detention: serious physical handicap, advanced age, short term fatal prognosis

50. Prisoners with serious physical handicaps and those of advanced age should be accommodated in such a way as to allow as normal a life as possible and should not be segregated from the general prison population. Structural alterations should be effected to assist the wheelchair-bound and handicapped on lines similar to those in the outside environment.
51. The decision as to when patients subject to short term fatal prognosis should be transferred to outside hospital units should be taken on medical grounds. While awaiting such transfer, these patients should receive optimum nursing care during the terminal phase of their illness within the prison health care centre. In such cases provision should be made for periodic respite care in an outside hospice. The possibility of a pardon for medical reasons or early release should be examined.

D. Psychiatric symptoms, mental disturbance and major personality disorders, risk of suicide

52. The prison administration and the ministry responsible for mental health should co-operate in organising psychiatric services for prisoners.
53. Mental health services and social services attached to prisons should aim to provide help and advice for inmates and to strengthen their coping and adaptation skills. These services should co-ordinate their activities, bearing in mind their respective tasks. Their professional independence should be ensured, with due regard to the specific conditions of the prison context.
54. In cases of convicted sex offenders, a psychiatric and psychological examination should be offered as well as appropriate treatment during their stay and after.
55. Prisoners suffering from serious mental disturbance should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. The decision to admit an inmate to a public hospital should be made by a psychiatrist, subject to authorisation by the competent authorities.
56. In those cases where the use of close confinement of mental patients cannot be avoided, it should be reduced to an absolute minimum and be replaced with one-to-one continuous nursing care as soon as possible.
57. Under exceptional circumstances, physical restraint for a brief period in cases of severely mentally ill patients may be envisaged, while the calming action of appropriate medication begins to take effect.
58. The risk of suicide should be constantly assessed both by medical and custodial staff. Physical methods designed to avoid self-harm, close and constant observation, dialogue and reassurance, as appropriate, should be used in moments of crisis.
59. Follow-up treatment for released inmates should be provided for at outside specialised services.

E. Refusal of treatment, hunger strike

60. In the case of refusal of treatment, the doctor should request a written statement signed by the patient in the presence of a witness. The doctor should give the patient full information as to the likely benefits of medication, possible therapeutic alternatives, and warn him/her about risks associated with his/her refusal. It should be ensured that the patient has a full understanding of his/her situation. If there are difficulties of comprehension due to the language used by the patient, the services of an experienced interpreter must be sought.
61. The clinical assessment of a hunger striker should be carried out only with the express permission of the patient, unless he or she suffers from serious mental disorders which require the transfer to a psychiatric service.
62. Hunger strikers should be given an objective explanation of the harmful effects of their action upon their physical well-being, so that they understand the dangers of prolonged hunger striking.
63. If, in the opinion of the doctor, the hunger striker's condition is becoming significantly worse, it is essential that the doctor report this fact to the appropriate authority and take action in accordance with national legislation (including professional standards).

F. Violence in prison: disciplinary procedures and sanctions, disciplinary confinement, physical restraint, top security regime

64. Prisoners who fear acts of violence including possible sexual offences from other prisoners for any pertinent reason, or who have recently been assaulted or injured by other members of the prison community, should be able to have access to the full protection of custodial staff.
65. The doctor's role should not involve authorising and condoning the use of force by prison staff, who must themselves take that responsibility to achieve good order and discipline.
66. In the case of a sanction of disciplinary confinement, any other disciplinary punishment or security measure which might have an adverse effect on the physical or mental health of the prisoner, health

care staff should provide medical assistance or treatment on request by the prisoner or by prison staff.

G. Health care special programmes: sociotherapeutic programmes, family ties and contacts with the outside world, mother and child

67. Sociotherapeutic programmes should be organised along community lines and carefully supervised. Doctors should be willing to co-operate in a constructive way with all the services concerned, with a view to enabling prisoners to benefit from such programmes and thus to acquire the social skills which might help reduce the risks of recidivism after release.
68. Consideration should be given to the possibility of allowing inmates to meet with their sexual partner without visual supervision during the visit.
69. It should be possible for very young children of detained mothers to stay with them, with a view to allowing their mothers to provide the attention and care they need for maintaining a good state of health and to keep an emotional and psychological link.
70. Special facilities should be provided for mothers accompanied by children (crèches, daynurseries).
71. Doctors should not become involved in administrative decisions concerning the separation of children from their mothers at a given age.

H. Body searches, medical reports, medical research

72. Body searches are a matter for the administrative authorities and prison doctors should not become involved in such procedures. However, an intimate medical examination should be conducted by a doctor when there is an objective medical reason requiring her/his involvement.
73. Prison doctors should not prepare any medical or psychiatric reports for the defence or the prosecution, save on formal request by the prisoner or as directed by a court. They should avoid any mission as medical experts involved in the judicial procedure concerning remand prisoners. They should collect and analyse specimens only for diagnostic testing and solely for medical reasons.
74. Medical research on prisoners should be carried out in accordance with the principles set out in Recommendations No. R (87) 3 on the European Prison Rules, No. R (90) 3 on medical research in human beings and No. R (93) 6 on prison and criminological aspects of the control of transmissible diseases including Aids and related health problems in prison.

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European Reintegration Offenders Services project
This website presents the European Reintegration Offenders Services project, which is made of three major components in France, Great Britain and Italy.
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Facts About Prisons and Prisoners
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International Rehabilitation Council for Torture victims
http://www.irct.org/
Justice Action
http://www.interights.org/
Lawyers for Human Rights
http://www.lchr.org/

See also on the same site the penal reform project page

http://www.niza.nl/lhr/penal/penalnav.htm

Moscow Center for Prison Reform

http://www.prison.org/

NACRO/The National Association for the Care and Resettlement of Offenders (UK).

http://www.nacro.org/

CESDIP/Centre for sociological studies on law and penal institutions (French).

http://www.msh-paris.fr/cesdip

International Centre for Criminal Law Reform

http://www.icclr.law.ubc.ca/

International Centre for Prison Studies

http://www.kcl.ac.uk/icps

International Monitor Institute

http://www.imisite.org/

Library of Congress

Country studies

http://lcweb2.loc.gov/frd/cs/cshome.html

Oxford Centre for Criminological Research

http://www.crim.ox.ac.uk/

Raoul Wallenberg Institute.

Institute of Human Rights and Humanitarian Law.

http://www.ldc.lu.se/raoul/

School of Forensic Science and Criminology

University of Lausanne (Switzerland)

http://www.unil.ch/ipsc/

The Penal Lexicon

http://www.penlex.org.uk/

University of Oldenburg/Germany (Heino Stöver)

http://www.uni-oldenburg.de/fb3/politik2/infekt/infekt.html

World Health Organisation

The WHO Health in Prisons Network

www.hipp-europe.org

http://www.qed.org.uk/injectcontents.html

www.prisoninitiative.nm.ru

FEED-BACK FORM

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