Co-operation Group to Combat Drug Abuse and Illicit trafficking in Drugs

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"Prison Drug Treatment Systems Overview"

Research project and feasibility study

Draft Project Outline

Introduction

The prevalence of problematic drug use among prisoners is high in European prisons compared to the general population. In particular injecting drug users are exposed to various health risks namely overdosing, abscesses, and the transmission of blood-borne viruses such as hepatitis B/C or HIV. In addition to these public health concerns, there are a number of human rights violations reported in European prisons, as documented by the European Court of Human Rights and the European Committee for the Prevention of Torture an Inhuman or Degrading Treatment or Punishment (CPT). As a partial agreement of the Council of Europe the Pompidou Group aims at tackling these issues in line with Council of Europe standards such as the European Prison Rules that apply equally to the provision of healthcare for problems related to drug use.

Drug treatment and drug services in general in the community as well as in custodial settings vary considerably throughout Europe. The country overviews of the European Monitoring Centre on Drugs and Drugs Addiction (EMCDDA) draw a differentiated picture of the situation in Europe. However, prison issues are only touched when describing the situation in the community[1]. Also in the Selected Issue on "Prisons and Drugs in Europe-The problem and responses" of the EMCDDA[2], released in November 2012, the situation of the candidate and potential candidate countries has not been described.

The general objective of the Pompidou Group research project "Prison Drug Treatment Systems Overview" is to improve health (HIV/AIDS/Hepatitis) and drug dependence in prisons in line with

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[1] http://www.emcdda.europa.eu/countries

[2] http://www.emcdda.europa.eu/publications/selected-issues/prison

human rights standards through the dissemination of best practices and improvement of the cooperation of drug treatment providers and prison administrations.

More specifically, the project aims to research quantitative and qualitative data on:

- Prison information (Number of prisons, populations, number of drug users, epidemiology of drug use, HIV, hep B/C, other STIs, TB)
- Description of existing drug services, both drug-free oriented as well as harm reduction services and drug treatment philosophies
- Description of drug treatment service provider
- Cooperation of intramural and extramural drug services
- Organisation, legal background (e.g. “therapy instead of punishment”), and structure of drug treatment systems
- Specialities in countries and best practice examples
- Critical analysis of drug treatment systems in prisons (strength and weaknesses).

The ten countries in focus of the planned study are:

- Albania
- Bosnia and Herzegovina
- Georgia
- Kosovo*
- The former Yugoslav Republic of Macedonia
- Moldova
- Montenegro
- Serbia
- Russia
- Ukraine

Preparatory meeting

The lead researcher of the project, Professor Heino Stöver, selected eligible researchers from the 10 countries based on their excellent work as researchers in previous projects and their linguistic skills. On 19 February 2014 the researchers met in the European Youth Centre of the Council of Europe in Budapest and agreed on working arrangements, timeline and the methodology of the research. The first draft of the country reports will be submitted by 30 June 2014 which will then be edited and proofread by tandems (peer review). After the finalisation the reports will be sent to the responsible Ministry of each country for feedback by 31 July. 16-17 September 2014 the researchers will meet again for the discussion of the final report and analysis of results. In September and October the publication will be finalised and a summary of results could be presented at the Ministerial Conference of the Pompidou Group in November 2014.

Feasibility Study

In 2013 the Pompidou Group commissioned Prof Heino Stöver to conduct a feasibility study to assess whether there are enough data already existing to draw a detailed picture on the drug situation in the above mentioned countries, and if not, to suggest experts to help with such (i) an inventory and (ii) to elaborate recommendations of how to overcome existing barriers in implementing European standards of health care for drug using prisoners.

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1. Estimation of available data in the countries

Generally the EMCDDA delivers overviews over country specific drug-related data (legal, treatment coverage etc.) not only for Member-States, but also for Candidate Countries and Potential Candidate Countries[3]. However for the latter countries only limited data are available about the specific situation regarding treatment of drug dependence in remand prisons, prisons, and police arrest.

Looking at the general international and foremost European situation there is an estimated 135 prisoners per 100 000 population. This is quite similar to the level of incarceration in Europe to that in Australia (134 per 100 000) and higher than that in Canada (117 per 100 000). Considerably higher levels of imprisonment are reported in the United States (743 per 100 000 in 2009) and Russia (590 per 100 000) (Aebi and Del Grande, 2011; Walmsley, 2012).

Looking at the nine countries in the focus of the study (table 1) there is a considerable range in the prison population rate per 100,000 inhabitants. While Kosovo* is far below the European average, there are some other countries slightly below the European average data (like “The former Yugoslav Republic of Macedonia”), some countries slightly higher (Albania, Serbia, Montenegro), and some are considerably higher (Moldova, Ukraine, Georgia).

Table 1: Prison population rate (per 100 000 inhabitants):

Country	**Year**	**Prison population rate (per 100,000 inhabitants)**	**Source**
Albania	2010	148,2	INSTAT (Albanian Institute of Statistics) 2011 census4
Bosnia and Herzegovina	2009	3200 prisoners	Ministry of Justice BiH
Georgia	2010	533.9	Council of Europe
Kosovo*	2010	c. 66	World Prison Population List (ninth edition)
The former Yugoslav Republic of Macedonia	2011	122.2	Council of Europe, SPACE I - 2011
Moldova	2008	191.3	Ministry of Justice
Montenegro	2009	156.5	Council of Europe, SPACE I - 2009
Serbia	2010	153.2	Council of Europe, SPACE I - 2010

[3] http://www.emcdda.europa.eu/publications/country-overviews/ge

[4] Institute of Statistics of Albania (INSTAT) (2011), ‘Albania population and housing census 2011’, INSTAT

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Ukraine	2010	332.4	Council of Europe, SPACE I - 2010

A heterogeneous picture can also be found when looking at the degree of introduction of European standards of drug treatment in prisons. Some countries do respond to the challenges of drug use adequately to their response in the community, others are at the beginning, or just started to harmonize their drug policies for prisons with that of the communities. This relates especially to those measures that are controversially discussed in other European countries as well: medication assisted treatment (or opioid substitution treatment), needle and syringe programs, screening, testing, diagnosing, antiretroviral treatment (HIV), antiviral treatment (HBV, HCV) etc[5]. The above mentioned EMCDDA (2012) publication “Prisons and Drugs in Europe-The problem and responses” is indicating the wide variety of prevalence and quality of drug services in prisons.

1.1. Cross cutting issues

Looking at the situation in general some cross cutting issues turn up, which are similar to what has been experienced in other European countries some years ago or what seems to be a prevailing problem.

- Gender specific responses for drug using women both at policy and practical levels are not developed or implemented with particular attention to their specific healthcare needs. Women who use drugs require specialized treatment services that take into account their specific needs. Often without treatment, imprisonment becomes a revolving door for drug using women (see Eurasian harm Reduction et al. 2012).

- Often rigid drug laws are responsible for the high number of prisoners or the high number of drug users among the prisoners. Often the opportunity of “therapy instead of punishment” (applied in most prisons of the current EMCDDA Member States). Thus changes and amendments to drug legislation (criminal and administrative) might contribute to clear definitions in the drug laws on the quantity of drugs for the personal use, possession and trafficking, and when a drug dependent prisoner might leave the prison in order to undergo an in-patient or out-patient treatment.

- Regarding financing: many of the countries are in transition from former Yugoslav or Russian organized states to independent states. Moreover the wars on the territory of the former Yugoslavia contributed to the financial and economic burden of the countries in focus of this study.

1.2. Results and recommendations from a previous study

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[5] See for European standards in HIV/AIDS and drug treatment: “Comprehensive Package”: http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf (for communities) and for custodial settings: http://de.scribd.com/doc/168325526/UN-HIV-and-Prison-Policy-Brief

The UNODC project “Ensuring relevant authorities act to contain the HIV/TB/Hepatitis C epidemics among drug users and in prison settings in Albania, Serbia and the FYR of Macedonia made some recommendations, which could be taken as an example for a development of the situation of drug using/dependent prisoners in the six other countries which are in the focus of this study:

1.2.1 The assessment of country and prison-related policies resulted in a number of findings and recommendations for action:

Introduce policy and legislative changes, and increase political will for harm reduction measures, such as needles and syringes, safe tattooing equipment (all countries).

Develop close working links in health care delivery between Ministry of Justice and Ministry of Health so as to ensure high standards of treatment, protection for personnel, joint training of professionals in modern standards of disease control, continuity of treatment between the penitentiary and outside society, and unification of statistics (see also WHO 2003). In the long run transfer health care services from jurisdiction of Ministry of Justice to Ministry of Health; and improve collaboration between field professionals, civil society and decision makers (all countries).

Develop harm reduction programs in prisons according to the proposed strategies in the Comprehensive Package of the UNODC (2009; all countries).

Develop clear and detailed protocols and standards giving a practical guidance for HIV; hepatitis, tuberculosis and substitution treatments in prisons. This is particularly necessary when there are multi-professional staff teams working together, in order to provide consistent quality of services. The protocols need to be developed according to international evidence-based standards and national guidelines.

Substantially increase access to long term OST, with a clear protocol, sustained financial coverage and associated psycho-social support. Ensure sustainability of OST for prisoners (Albania, Serbia).

Increase anonymous, confidential and low threshold access to condoms and lubricants (all countries).

Improve HIV and HCV testing, prevention and treatment services; and improve/introduce screening of TB in prisons (Albania and Macedonia).

Improve measures to protect prison staff (hepatitis B vaccination for example) in all countries.

Consider introducing post exposure prophylaxis (PEP) in all countries, which is unavailable at the moment.

1.2.2. The assessment of training needs concluded that in all three countries both prison staff’s and prisoners’ capacity should be built in a number of areas:

Training should focus on HIV, hepatitis B and C, and TB prevention, treatment and care to ensure continuity of harm reduction interventions and has to be delivered to prison staff, administrators and health professionals.

As social rehabilitation programs are generally lacking in prisons, special emphasis on social skill training and relapse prevention (especially with regard to overdose prevention) is also required.

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The trainings should be systematic and regular, incorporated into curricula for prison staff in prison staff school and other educational systems where appropriate. Special attention should be paid to new staff. Police officers also need to be included in HIV prevention trainings, in particular if they are in contact with drug users.

Prisoners' health education in HIV, HCV and TB has also been identified as a key area.

Furthermore the organization of a conference on prison health for community and prison professionals, and NGO representatives, has been considered as useful to exchange experiences and knowledge.

***1.2.3. The Technical Working Groups* (TWG) were established in Albania, Macedonia and Serbia to:**

Ensure ***cooperation between government and civil society*** – TWGs are led by one governmental and one civil society representative, include representative of both sectors.

Lead advocacy and introduction of policy changes to increase access to HIV, HCV and TB prevention in prison settings.

Ensure optimization of national efforts on prison issues by coordinating activities between other national strategies (e.g. National AIDS or TB Strategy) and links between them. For example, in Macedonia the added value of the Technical Working Group is connecting the other committees – working on National HIV Strategy, National Drugs Strategy and National Health in Prisons Strategy – through having participants from all 3 committees. Thus the TWG will be well positioned to coordinate HIV, HCV and TB prevention issue is relevantly and consistently addressed in all 3 national strategies.

1.3. Prison-specific country information

1.3.1. Albania

Articles 283–286/a define serious sanctions for people committing drug-related crimes: 5–10 years' imprisonment for production, selling, distribution and possession of drugs, and 7–15 years for trafficking.

Legal statistics provide some evidence of the impact of drug misuse on the criminal justice system. In 2009 647 drug cases were registered, 568 offenders were prosecuted. These represent 5 % of all offences (13,100) and 4.7% of offenders (11,989) registered in Albania (UNODC 2012). Around 30% (113) of drug offenders had prior offences (EMCDDA, 2012).

There are 21 prisons in Albania, the largest with 900 inmates. In 2010, there the system held 4,689 prisoners, although the official capacity was for 3,480. No reliable statistics are available but its estimated 270 drug users are incarcerated or on probation (UNODC 2012). The support of (drug dependent) prisons comprises of prison doctors and separate services who manage drug addiction and mental health. There are no Prisons department protocols for the assessment and management of drug dependent prisoners. Training for health staff is provided by IPH, and UNODC delivers treatment packages.

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EMCDDA country report for Albania[6] states that methadone maintenance treatment (MMT) provision was started in 2005 by the NGO Aksion Plus, which had been funded by the Soros Foundation. The overall number of clients who began a methadone treatment, from June 2005 until the end of 2010, was 640, from which 34 were prisoners. This was in accordance with an agreement with the Ministry of Justice.

Arian Boci (see contact list) called the General Prison Administration and they confirmed that the situation is still the same. Methadone is being provided by A+ to treat former drug user.

Furthermore EMCDDA states that from 2008 onwards the NGO “Stop AIDS”, in collaboration with the General Directorate of Prisons and with support from UNICEF, UNFPA, the United Nations Development Programme (UNDP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, periodically organised a series of awareness-raising and harm-reduction activities (in Tirana, Durres, Kavaja, Vlora, Peqin, Rrogozhina and Lezha) with prisoners and prisons’ social work, health and security staff. A series of leaflets and two brochures on HIV among prisoners, were distributed to prisoners and their family members as well as prison staff.

Stop AIDS also offers harm reduction activities to prisoners in six prisons, focusing on information, and counseling, peer education, HIV, syphilis, hepatitis B and C testing, training of medical and psycho-social personnel and provision of condoms.

Aksion Plus also supports limited provision of methadone to some prisons, in order to continue treatment of patients who have been incarcerated. This has been done in accordance with an agreement with the Ministry of Justice. In general, imprisoned patients are tapered off methadone, although in the case of some prisoners with serious mental health problems, Aksion recommends to prison authorities that methadone is continued indefinitely.

When people are first arrested, they are held in pre-detention or in police commissariat for up to 72 hours before transfer to the prison system. Aksion Plus also provides some methadone to arrested patients in pre-detention, although there appears to be no written protocol or official arrangements under which this is done.

Aksion Plus also works with police custody, and doses patients in some cells. An MOU between Aksion Plus and the Ministry of Justice, General Administration of Prisons, was signed in 2006, under which Aksion Plus provides methadone treatment for arrestees and prisoners. It works with 2 prisons – the doctor assesses patient in prison, has Aksion protocol, and writes a note, it is delivered to Aksion who supply methadone to be administered in gaol. The methadone is for tapering during sentences, unless the patient has serious mental health issues when Aksion recommends maintenance.

1.3.2. Bosnia Herzegovina

Drug treatment has not been implemented in the prison setting so far, but there are plans to implement drug treatment in prisons within the current national drug strategy.
In 2010 the NGO Viktorija conducted a survey on HIV and HCV prevalence in prisons through administration of testing to 143 persons in Tunjice prison. Among those tested 42 were IDUs, 78 other prisoners and 23 were employees. Approximately 50 % of IDUs tested positive for HCV. One

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[6] http://www.emcdda.europa.eu/publications/country-overviews/al#tresp

percent of other (non-IDU) prisoners and none of employees tested positive for HCV. No case of HIV infection was detected.

1.3.3. Georgia

EMCDDA's country report states: Possession of any amount of drugs is a criminal offence under the Penal Code of Georgia (Article 260), with no differentiation between the possession of drugs for personal use or for trafficking. This article provides for quite strict punishment: up to 11 years' imprisonment for a small quantity of drugs; 7–14 years for large amounts; and 8–20 years or life imprisonment for very large amounts of drugs. For the majority of substances that are widespread in Georgia there is no legal definition of what constitutes a small quantity, and therefore any amount found in the illegal possession of a person is deemed a large amount, leading to severe punishment.
The crime of 'repeated drug use' is punishable by imprisonment of up to one year and with a fine with a mandatory minimum of GEL 2 000 (approximately EUR 1 000) and no upper limit.

Thus, although the rate of imprisonment for drug consumption related offences has been gradually decreasing in the last three years, the number of people fined or subjected to conditional sentencing for these offences remains high relative to the population and the estimated number of drug users.

EMCDDA (2013) reports that methadone is available in the GFATM-supported detoxification programmes in prisons. In 2011, some 107 prisoners were detoxified using methadone in a treatment site at Prison no. 8.

1.3.4. Kosovo*

Unauthorized import and export of dangerous, narcotic or psychotropic substances is punished by a fine and imprisonment for three to 10 years, according to Article 229.
In EMCDDAs country report it is said that in 2008 the Rapid Assessment and Response (RAR) study among young people, injecting drug users and prisoners was implemented in cooperation with the Kosovo* offices of the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) (Brisson et al., 2009). The sample size was 1 302 respondents aged 15–24. Lifetime cannabis use was found to be 3.8 %, and was more prevalent among males (5.5 %) than females (2.2 %), and among those aged 20–24 (6.7 %) than those under the age of 18 (1.7 %). Most of the young people had started using cannabis at the age of 17, with no significant differences between genders. Ecstasy use was reported by 0.6 % of respondents, and heroin and amphetamine use (or other forms of doping) by 0.4 %. Approximately 0.2 % had tried cocaine. Approximately 2.6 % of the respondents reported use of illegally obtained prescription drugs such as Trodon, Tramal, Bensedin, Fortral, Valeron and methadone/Heptanon. Respondents reported that they started taking these prescription drugs between the age of 13 and 20; the mean age was 17.

Prisons offer preventive activities to inmates in the form of health education and the promotion of information on drugs and infectious diseases, including sexually transmitted diseases and HIV/AIDS. These activities are implemented by Labyrinth within the framework of a project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

About half (52.6 %) of new treatment clients in 2011 had been imprisoned at least once in their lifetime (44.4 % in 2010).

1.3.5. The former Yugoslav Republic of Macedonia

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A person who induces another to take narcotics, psychotropic substances and precursors, or who gives narcotics, psychotropic substances and precursors to another for this person or someone else, or who makes available premises for the taking of narcotics, psychotropic substances and precursors, or in some other way enables another to take narcotics, psychotropic substances and precursors, shall be punished with imprisonment of three months to five years. If the crime is committed toward a juvenile, or toward several persons, or if it causes especially severe consequences, the offender shall be punished with imprisonment of one to 10 years. The strategy for the socialisation and social adaptation of convicts for 2010–12 also sets out special measures to improve access to drug treatment programmes in prisons.
In the EMCDDAs country report mentions that there are three drug units in the following prisons: Idrizovo Prison in Skopje, Skopje Prison and Bitola Prison, which also have methadone maintenance treatment centres. Idrizovo Prison has had a methadone maintenance treatment centre since 2006. It has a 120-bed medical facility where people who are addicted to drugs can be treated alongside other patients. Its biochemistry laboratory is able to perform screening tests for the presence of psychoactive substances in urine. Prisoners in other prisons are also receiving methadone substitution therapy, in cooperation with local treatment centres and with the University Clinic for Toxicology (for buprenorphine).

In 2011 a third (746) of all prisoners registered (2,212) on 31 December 2011 were drug users; 414 of them were on a substitution maintenance programme with methadone and 17 prisoners were on treatment with buprenorphine. In 2008 approximately 649 of 2 101 prisoners were drug users. In Idrizovo Prison 388 of 1 316 prisoners were drug users in 2011. Of these, 154 were on methadone maintenance treatment and five received buprenorphine based treatment.

1.3.6. Moldova

The EMCDDA reports that by the end of 2008, in the penitentiary system (5 institutions involved) 142 drug users had been involved in substitution treatment with methadone at some point; 32 of them were receiving treatment at the end of the year (Soros Foundation — Moldova 2009).

The basic components of the Harm Reduction Strategy within the framework of penitentiary institutions are as follows:

- information/education/outreach about HIV/AIDS and their prevention in the context of high-risk practices (distribution of informational materials and condoms, workshops);
- needle exchanges for IDUs.

Activities for inmates are conducted particularly within the medical services of the penitentiary institutions, with the involvement of outreach employees recruited from among the inmates. In 2008, within the framework of the implementation of the Harm Reduction Strategy, the information component was implemented with informational materials distributed and workshops on HIV/AIDS prevention organized in all 18 penitentiary institutions, while the needle exchange points functioning in seven of them were open on a 24-hour basis, seven days a week. No data are available on the number of beneficiaries of harm reduction programmes in the penitentiary system, because of the refusal of the outreach workers, who themselves are inmates, to provide such data.

1.3.7. Montenegro

Article 300 stipulates that ‘Anyone who unlawfully produces, processes, sells or offers for sale, or who for the purpose of selling buys, keeps or transports or mediates in the selling or buying, or in some other way unlawfully releases for circulation the substances or preparations pronounced to be narcotics, shall be punished by an imprisonment sentence of two to ten years’.

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EMCDDA's country overview states that in 2009, the Institute for Execution of Criminal Sanctions (IECS) has treated 37 convicted drug users, or 10 % of the total number of convicted persons. In 2009, six prisoners received methadone, while in 2010, 10 prisoners were on the MMT programme. The methadone was prescribed only to those prisoners who at their initial mandatory medical examination informed the physician of the IECS that they have been included in MMT programme prior to the conviction. This also had to be confirmed by their signature in the presence of the physician.

Since 2006, NGO Juventas has also been running the "Open with Prisoners" project inside Podgorica Prison, which provides information and educational materials on harm reduction to prisoners and to the prison staff. A counselling centre has been established within the prison, and also in the Special Prison Hospital, and harm reduction is one of the subjects covered during counselling sessions with prisoners. In total, 70 group counselling sessions were conducted with 190 inmates, 197 individual sessions with 111 inmates, 4 049 pieces of printed materials were distributed, and 38 prison staff were trained in HR.

Data from the Special Prison Hospital in Podgorica Prison to treat inmates show that annually a decreasing number of prisoners has been treated (21 in 2009).

1.3.8. Serbia

According to the Criminal Code, unauthorized selling or offering of narcotic drugs for sale is punishable by three to 12 years. According to the same law, whoever unlawfully grows poppy seeds, psychoactive hemp or other plants that generate or contain narcotic drugs shall be punished by imprisonment of six months to five years. If the above-mentioned offence is committed by a group, or if the offender has organised a network of dealers or middlemen, the offender shall be punished by imprisonment of five to 15 years.

The Republic of Serbia belongs to countries with low prevalence of HIV infection. The registered prevalence of HIV is 0, 02% in the country[7]. In the UNODC report (2012) it is stated that some local reports indicate that in the prison context, in some of the prisons, administration has maintained a practice of conducting systematic medical check-ups and mandatory testing for HIV, hepatitis B and C, as well as chest x-rays; this is particularly concerned with the prisons where juveniles are allocated[8]. The same data though indicates that due to financial reasons, testing for HCV, HIV and HbsAG is not done for all prisoners, but only for those with transaminases[9].
There are 28 prison institutions and 15,092 prisoners in Serbia.10 11,24% of all prisoners are in pre-trial. Compared to men, the number of women in prison is Serbia is low. The number of female prisoners has been fluctuating between 300 and 600.

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[7] Combined second and third periodic reports of States parties – Serbia, Committee on the Elimination of Discrimination against Women, 16 March 2011, CEDAW/C/SRB/2-3, paras 239-243

[8] http://www.helsinki.org.rs/doc/zatvori%20-%20march%202012%20-2.pdf; accessed on 7 September, 2012

[9] http://www.helsinki.org.rs/doc/zatvori%20-%20march%202012%20-2.pdf; accessed on 7 September, 2012

[10] Combined second and third periodic reports of States parties – Serbia, Committee on the Elimination of Discrimination against Women, 16 March 2011, CEDAW/C/SRB/2-3, paras 239-243

[11] Combined second and third periodic reports of States parties – Serbia, Committee on the Elimination of Discrimination against Women, 16 March 2011, CEDAW/C/SRB/2-3, paras 239-243

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Available data show that in 2009, approximately 4,495 drug addicts were admitted to prisons (men and women).12 60 % of them used heroin before detention and 80% used marijuana.13 The reform strategy of Serbia notes: '…..In prison population in the Republic of Serbia a number of detained or sentenced for the commitment of severe criminal acts with elements of violence and organized crime increases, the age limit of criminals reduces and a number of addicts increases, primarily drug addicts (over 60% of prisoners had drug experiences or are active drug addicts'.14 This information further shows that not only drug involved prisoners have experience of drug use (including injecting drug use) but also those incarcerated for any types of crime. A discrepancy though which needs to be highlighted is that there is no segregated data on how many women prisoners are dependent on drugs hence in need of treatment and/or harm reduction services.

Lately, the structure of prisoners has significantly changed, and there are more and more persons who are drug addicts.15 The annual report of the prison service indicates that only in 2011 there were 1,688 people admitted to prisons for their drug use.16 From this number, juveniles comprised 5 and no female numbers are indicated.17

The healthcare system for drug addicts in prisons is improving. In 2009, voluntary and confidential counseling and testing for HIV and hepatitis C of all newly admitted patients, individual and group counseling on risk behavior, HIV, HCV and overdosing were implemented in healthcare services in penal institutions. Methadone substitution therapy can be administered in penal institutions to opiate-addicted clients. In 2011, the number of registered drug addicts among prisoners was 4,929 (detained, convicted, juveniles, punished for minor offence); in 2010 there were 6,211. The number of people deprived of their liberty in Serbia as of 31 December 2011 was 11 094.

As of 31 December 2011, a total of 128 people were receiving substitution treatment in prison. For 2010 and 2009 the numbers of OST clients in prison were 119 and 103 respectively. With the support of the Mission of the OSCE, drug-free units were opened at two penal correctional institutions: in Nis and the Special Prison Hospital in Belgrade. The prerequisite for prisoners to be at those units is their absolute abstinence from all psychoactive substances (Ministry of Justice Prison Administration, 2011).

1.3.9. Ukraine

EMCDDA's report from 2011 states for Ukraine "During the past 10 years no research on drug use has been conducted among persons serving their sentences in institutions of punishment and under investigation in prison" (p. 68). Thus mainly formal data are available on seizures, trafficking

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[12] Annual report of Ministry of Justice Prison Administration

[13] Combined second and third periodic reports of States parties – Serbia, Committee on the Elimination of Discrimination against Women, 16 March 2011, CEDAW/C/SRB/2-3, paras 239-243

[14] Combined second and third periodic reports of States parties – Serbia, Committee on the Elimination of Discrimination against Women, 16 March 2011, CEDAW/C/SRB/2-3, paras 239-243

[15] Combined second and third periodic reports of States parties – Serbia, Committee on the Elimination of Discrimination against Women, 16 March 2011, CEDAW/C/SRB/2-3, paras 239-243

[16] 2011 Annual Report on Prison Administration Operations, pp. 110-135

[17] 2011 Annual Report on Prison Administration Operations, pp. 110-135

and prisoner-general population ratio etc. In the report nothing is being said about treatment modalities for drug users, difficulties in introducing medication assisted treatment (OST), or any other data on self-help groups, 12-steps programmes etc.

The author recently carried out a study for the UNODC and USAID (2012) on the situation in prisons. Some results are being presented on the situation regarding drug treatment in Ukrainian prisons:

1.3.9.1. Insufficient coverage of prevention and absence of harm reduction measures

Mostly NGOs are delivering preventive activities in prisons, which consist mainly of group counseling, lecturing or handing out information. After a few years of intervention in prisons, there is an important interest for volunteer trainings and self-help group developments. SPSU agreed to the involvement of NGOs in the training of prisoners (peer education based programs; field visit). Manuals addressing this issue are available (see http://www.aidsalliance.org.ua/ru/library/our/2011/module.pdf). NGOs publish important information in form of manuals or videos (for example: AFEW or International HIV/AIDS Alliance in Ukraine).

Prevention was assessed as being insufficient (UNAIDS 2012) since its scale was limited to the available funds within GFATM Rd6 Project. The targets of preventive measures have not been reached (only 15-20% have been reached – personal communication during field visits).

Prison authorities have been reported to be reluctant to recognize the existence of male to male sex/contextual homosexuality (UNAIDS 2009). This has been confirmed at prison/field visits of the author in 2012.

Condoms provision is reported to be irregular (UNAIDS 2009).Condoms are available only for conjugal visits. Private visits are allowed three to four times a year, but only a minority does use them or are allowed to use them (14%). In the women's prison visited only 10% of the female prisoners receive conjugal visits. Therefore, even if it is indicated to provide condoms in this context, the impact on HIV/STI-related prevention in prisons seems to be not very significant.

When NGOs are present in the penitentiary institutions condoms availability is greater, and HIV awareness is more raised (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011).

Harm reduction measures virtually do not exist at the moment in Ukrainian prisons. Prison authorities remain opposed to it (UNAIDS 2009; UNAIDS 2012). Prison-based needle syringe program (PNSP) has been planned in 2005, it was ready to work, a Memorandum of Understanding has been signed, 3 pilot sites had already been selected, training has been carried out, a full algorithm has been elaborated, a PNSP order was drafted, but in the last moment the pilot has been rejected. All planned activities were stopped.

1.3.9.2. Lack of drug dependence treatment and in particular of OST

Drug dependence is not considered as an illness but as an offence. This is the main obstacle for treating drug dependent prisoners. According to experts there is a certain amount of denial to treat addiction in prison pretending officially that "these (drug) problems don't exist". The almost complete absence of any form of drug dependence treatment (e.g. OST) is clearly contributing to a high risk situation in Ukrainian prisons. The underlying assumption is that during imprisonment no drug use is happening (although seizures suggest that there are numerous attempts to smuggle drugs in). Based on seizures the control measures are perceived as being very effective (field

visits). However, the fact that drugs are coming in via different ways shows that control strategies remain partly unsuccessful.

There is a high turnover of prisoners going through the prison system yearly and there is a high number of IDU inside the prisons. The impact of measures or absence of measures is therefore of utmost importance for the prisoners and for public health.

Although buprenorphine has been provided since 2004 and methadone since 2008 in the community in Ukraine, OST is inexistent at the moment in prisons, which is unethical (UNAIDS 2009; Balakireva, Sudakova et al. 2012). It has been reported that in a few cases in police arrest stations OST can be continued if provided by the doctor in the community, mainly on initiative and by payment of the detainee him/herself.

In general, fear of stigma is associated with delay in access to treatment among IDU (Wolfe, Carrieri et al. 2010). The prison services do not facilitate the access to treatment; on the contrary, prisoners face severe inequity. Prisons lack qualified staff and means to diagnose and treat people who need it (p 108 (UNAIDS 2009). In Ukraine, IDU and prisoners are the groups who have the most difficult access to prevention, care and support services (p.139 (UNAIDS 2012).

OST that was begun in the community is interrupted on imprisonment. The absence of continuity of OST therefore might result in abrupt detoxification in either police arrest or pre-detention, which again is a health burden for those IDUs suffering from BBVs (EMCDDA and Ukrainian Medical & Monitoring Center of Alcohol And Drugs of the Ministry of Health of Ukraine 2011). A working group including members of the Ministry of Internal Affairs, State Service on Drug Control, Ministry of Health, Ministry of Justice and the State Penitentiary Service of Ukraine is tackling the issue of opioid substitution treatment. A draft order has been elaborated by all the four Ministries in May 2011, which foresees that in police detention and then pre-trial prisons a continuation of OST should be done (in individual cases it is partly done in police detention, depends on the case). It has been submitted to the MoJ, and had been returned to MoH for re-consideration (November 2011). But one and a half year after first submission (October 2012), this order is still under consideration.

Modeling of services to address the HIV epidemic in Ukraine have shown that the most efficient way was to achieve a high level of access to opioid substitution maintenance therapy and to ARV (p 84 (UNAIDS 2012). This is currently not possible in prisons or other custodial settings.
Also there is a lack of any other form of drug treatment. Preparatory work to pilot ‘Atlantis’ (12-step Minnesota model) in prisons has been done, but was stopped later. However, these approaches are not considered to be evidence-based.

All in all IDUs in prisons do not benefit from the achievements and the progress of services that can be observed in the community.

2. Inquiry if there are major obstacles and risks for the research project

Major obstacles and risks might occur when researchers are not given permission by the authorities to visit prisons and/or to talk to prisoners. However, when talking to contact persons (see table 2) and during assessment missions the author undertook himself between 2011-2012 to Albania, Serbia, the FYR of Macedonia, and Ukraine no such barriers have been experienced. In the opposite there was a lot of interest in the research and in discussing and learning from European standards or practices in general regarding drug treatment in custodial settings.

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Furthermore, a lot of experts in the countries could be identified, who are able and willing to be involved in the research process. Their expertise might significantly contribute to carry out the envisaged study successfully.

Several experts of them are known to the author from previous studies and collaborations. The working relationships were reliable and productive.

Finally already some literature on the country specific situation in prisons in most of the countries does exist already. The study would not start from the scratch. The foreseen methodology could build on that in elaborating a very clear picture of the respective country situation in order to enrich the research process in the countries.

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