Standards for treatment of people with drug use disorders in custodial settings

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Standards for treatment of people with drug use disorders in custodial settings

Background paper for the activity "Developing comprehensive drug treatment systems in prison" within the Pompidou Group's Drug Policy Co-operation in South-East Europe (SEE)

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Council of Europe

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Acronyms

CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DUD	Drug use disorders
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
MAT	Medication-assisted treatment
MOUD	Medication for opioid use disorder
NGO	Non-governmental organisation
NPS	New psychoactive substances
OAT	Opioid agonist treatment
OST	Opioid substitution treatment
OUD	Opioid use disorder
PHC	Primary healthcare
PDL	People deprived of liberty
PWDUD	People with drug use disorders
SBIRT	Screening, Brief Interventions and Referral to Treatment
TB	Tuberculosis
TC	Therapeutic community
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Introductory remarks

The set-up of standards for comprehensive treatment of people with drug use disorders (PWDUD) in criminal justice systems needs to build on four cornerstones:

1. Drug use disorders (DUD) are health disorders.[1]
2. Healthcare for people deprived of liberty (PDL) is a whole state responsibility.[2]
3. PDL have the right to the highest attainable standard of health.[3]
4. Prison health is public health.[4]

1 implies that to implement appropriate treatment systems for PWDUD in criminal justice settings, not only healthcare staff but everyone responsible for persons in the criminal justice system, including police, prosecutors, courts, judges, prison administrations as well as custodial and probation staff, needs to understand the nature of DUD as health disorders caused by physiological brain alterations rather than a lack of willpower or weakness of character, or as criminal behaviour. Professional training and support for achieving this understanding is indispensable for the set-up of standards of drug treatment systems within the criminal justice system.

2 and 3 call for the commitment of state authorities in addition to the penitentiary administrations to providing healthcare to PDL, on the basis that it is the state (and not the penitentiary administration) that has taken away their liberty, and because PDL are unable to realise their rights to the highest attainable standard of healthcare themselves through the means at their disposal.

2 and 4 stress the importance of a whole state approach in providing for offenders with DUD the most appropriate legal framework and practice, respecting DUD as a health disorder rather than criminal behaviour and taking into account the individual and public health implications of DUD if not properly addressed. In addition, according to the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the US National Institute on Drug Abuse (NIDA), treatment of PWDUD has been shown to be highly cost-efficient from a public budget perspective.[5] This includes developing non-custodial measures for offenders with DUD whenever possible and, if imprisonment seems inevitable, the integration of treatment of imprisoned PWDUD with public health policies for epidemiological control, harm reduction, evidence-based treatment and continuity of care.

Therefore, to set up standards for treatment of PWDUD in the criminal justice system, the involvement of legislative bodies, the judiciary, governments with line ministries and the respective administrations, in addition to detention and penitentiary institutions and governmental and non-governmental healthcare services is necessary. Regardless of the pattern of healthcare governance the state has in place for people in the criminal justice system, close intersectoral co-operation is indispensable for adequate treatment of PWDUD in the criminal justice system, for care during application of non-custodial measures, during imprisonment and after release.

Methods for achieving these standards include raising awareness among members of the public as well as decision makers; revision and adaptation of legal regulations; and professional development and training for medical and non-medical staff caring for PWDUD in prisons as well as for the police, courts and judges. Development of guidelines or standard operational procedures should support the maintenance of acquired training knowledge. It goes without saying that the provision of human and material resources is indispensable, but much can be achieved through training and by building on existing resources.

1. WHO (2016), *International statistical classification of diseases and related health problems, 10th revision (ICD-10)*, World Health Organization, available at https://icd.who.int/browse10/2016/en#/F10-F19, accessed 31 October 2022.
2. UNODC/WHO (2013), "Good governance of prison health in the 21st century. A policy brief on the organization of prison health", United Nations Office on Drugs and Crime/World Health Organization, available at www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf, accessed 31 October 2022.
3. OHCHR (1966), International Covenant on Economic, Social and Cultural Rights, Office of the High Commissioner for Human Rights, available at www.ohchr.org/en/professionalinterest/pages/cescr.aspx, accessed 31 October 2022.
4. WHO (2003), Prison Health as part of Public Health, World Health Organization, available at www.euro.who.int/__data/assets/pdf_file/0007/98971/E94242.pdf, accessed 31 October 2022.
5. UNODC/WHO (2020), *International standards for the treatment of drug use disorders*, *Revised edition incorporating results of field-testing*, United Nations Office on Drugs and Crime/World Health Organization, available at www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders, accessed 31 October 2022.

When discussing standards of treatment for PWDUD in prison, it has become common, in accordance with the United Nations Standard Minimum Rules for the Treatment of Prisoners, to refer to "minimum standards". However, in treatment of health disorders and in keeping with the principle of equivalence of care, that is provision of the same quality standards of treatment for PDL as for patients in the community, the term "minimum standards" does not make any sense. Therefore, in this paper, the author refers to the currently accepted standards of treatment for PWDUD as stipulated in the internationally agreed-on documents listed in Literature Review B and C (pp. 24-6).

In keeping with international standards (see Literature Review A-C, pp. 23-6), background policies for developing standards of treatment of PWDUD in the criminal justice system should include:

- treatment and rehabilitation rather than punishment;
- treatment in full compliance with human rights and the principles of healthcare ethics;
- exhausting all possible non-custodial measures and treatment options, whenever possible, outside of prison;
- equivalence of care and close integration with community health services;
- harm reduction rather than unconditional abstinence;
- evidence-based treatment rather than ideological treatment concepts;
- treatment oriented to the needs of the individual patient rather than to the needs and constraints of the involved institution.

Drug use disorders

The recently published revised edition of WHO/UNODC's *International standards for the treatment of drug use disorders* presents a comprehensive explanation of DUD.

According to the 11th revision of the International Classification of Diseases (ICD-11) the term "drug use disorder" comprises two major health conditions: a "harmful pattern of drug use" and "drug dependence". A harmful pattern of drug use is defined as a pattern of continuous, recurrent or sporadic use of a drug that has caused clinically significant damage to a person's physical health (including blood-borne infections from intravenous self-administration) or mental health (such as a substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others. Substance dependence is defined in ICD-11 as a pattern of repeated or continuous use of a psychoactive drug with evidence of impaired regulation of use of that drug that is manifested by two or more of the following: (a) impaired control over substance use (including onset, frequency, intensity, duration, termination and context); (b) increasing precedence of drug use over other aspects of life, including maintenance of health and daily activities and responsibilities, such that drug use continues or escalates despite the occurrence of harm or negative consequences (including repeated relationship disruption, occupational or scholastic consequences, and negative impact on health); and (c) physiological features indicative of neuroadaptation to the substance, including: 1) tolerance to the effects of the substance or a need to use increasing amounts of the substance to achieve the same effect; 2) withdrawal symptoms following cessation of or reduction in the use of that substance; or 3) repeated use of the substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.

"Disorders due to drug use" comprise a broader category of health conditions that include drug intoxication, withdrawal syndrome and a range of drug-induced mental disorders. DUD often go hand-in-hand with a significant urge to use psychoactive drugs, which can persist, or easily be reactivated, even after a long period of abstinence. Very often DUD are associated with hazardous or harmful use of other psychoactive substances such as alcohol or nicotine, or with alcohol and nicotine dependence.

The nature of drug dependence is rooted in a complex dynamic interaction between biological, psychological and social factors. Neurobiological mechanisms range from inherited genetic vulnerabilities to disruptions of neuronal pathways in brain areas that regulate functions such as motivation, experience of pleasure, memory and learning (WHO 2004; Koob and Volkow 2016). Various psychosocial factors may increase the risk of both initiation to drug use and development of DUD. Family-related factors such as early childhood neglect, child abuse and parental modelling of substance use may contribute towards harmful patterns of drug use and drug dependence. At a societal or community level extreme poverty, displacement, and favourable norms and media attitudes towards drug use have been shown to increase vulnerability to DUD (UNODC 2015).

In addition to DUD, some individuals who use drugs develop other health conditions that are often associated with drug-related health risks and behaviours. Those who inject drugs are at high risk of exposure to blood-borne infections such as human immunodeficiency virus (HIV) or hepatitis C virus, as well as to tuberculosis (TB) infection. There is an increased risk of fatal overdose, road traffic and other injuries, cardiovascular and liver problems, violence and suicides. Drug dependence is associated with a reduced life expectancy: the mortality rate of people with opioid dependence is significantly higher than the rate in the general population and death occurs more often at a younger age (Degenhardt et al. 2018; GBD 2017 Risk Factor Collaborators 2018).

The relationship between substance use disorders and other mental health disorders is very complex. Often another mental health disorder predates the onset of substance use, putting affected individuals at greater risk of developing substance use disorders (WHO 2004). Other mental health disorders may develop secondary to the substance use disorder, due in part to biological changes in the brain resulting from substance use. The risk of developing drug dependence and psychiatric complications is particularly high when children and young adults are continuously exposed to the effects of drugs before their brain can fully mature, a process that usually occurs during their mid-twenties (Conrod and Nikolaou 2016; Silveri et al. 2016).

Medical research over many years has led to the conclusion that drug dependence is a complex, multi-factorial health disorder with well-documented biological and psychosocial mechanisms of evolvement. Scientific advances have also made it possible to develop effective treatment and care interventions that support PWDUD in changing their behaviour to improve their health. The overall public health approach to drug use and DUD has prompted the development of interventions that reduce short- and long-term harms to people using drugs. This has proved to be particularly useful for HIV prevention, treatment and care among people who inject drugs (WHO 2012b).

Perceptions of DUD have been changing in recent times among policy makers, health professionals and the public. There is a greater recognition that substance use disorders are complex health conditions with psychosocial, environmental and biological determinants, which need multidisciplinary, comprehensive and public health-oriented responses from different institutions and organisations working together. There is an increasing understanding that rather than being a "self-acquired bad habit", drug dependence is the result of a long-term interaction of biological and environmental factors including social disadvantages and adversities, and that it can be prevented and properly addressed to improve people's health and public safety.

Unfortunately, outdated views about DUD persist in many parts of the world. PWDUD, their family members and professionals working with them generally face stigma and discrimination. This has significantly compromised the implementation of quality treatment interventions, undermining the development of treatment facilities, the training of health professionals, and investment in treatment and recovery programmes. Evidence clearly shows that drug and other substance use disorders are best managed within the public health system, like other chronic medical problems such as HIV infection or hypertension. Nevertheless, the idea of including the treatment of DUD in healthcare systems still faces resistance, partly owing to a delay in transferring science to policy and ultimately to the implementation of evidence-based clinical practices.

In some countries, DUD are still seen primarily as a public safety and criminal justice problem, with the relevant agencies of the interior, justice or defence ministries handling responses to DUD by providing services, often without the supervision or engagement of the health ministry or other public health agencies and institutions. The exclusive use of law enforcement strategies and methods is neither an effective response to drug and other substance use disorders nor a cost-effective way of spending public funds. Biopsychosocial treatment strategies that acknowledge drug dependence as a multifactorial health disorder, treatable using medical and psychosocial approaches, can help reduce drug-related harms. This in turn will improve the health, well-being and recovery of affected individuals while reducing drug-related crime and increasing public safety and beneficial community outcomes (such as reduced homelessness, social welfare requirements and unemployment).

DUD often take the course of a chronic and relapsing disorder. This implies that treatment services have to work with patients over the long term – often for years and sometimes throughout a patient's entire life – maintaining contact, and offering crisis interventions and support when needed and at different levels of intensity. This is similar to the system of care for patients with other chronic diseases (such as diabetes, asthma and cardiovascular diseases). Such a system is designed to manage periods of remission and exacerbations by modifying interventions to match the severity of the problem at hand without raising the expectation that a short-term treatment episode will bring about a cure. Recognising the nature of drug dependence or ongoing drug use and the fact that they often involve relapses does not imply that managing them is ineffective and useless. On the contrary, appropriate treatment delivered repeatedly (even in the face of ongoing drug use or intermittent relapses to drug use) is essential for preventing drug-related deaths. It helps improve health and the quality of life despite persistent ill health and frequent social problems. Effective approaches to the prevention and treatment of substance use disorders and their health and social consequences can reduce harm to patients and their communities, and enhance the chances of achieving a long and healthy life (UNODC/WHO 2018).

Standards in the legal framework

Standards in the legal framework include a case law based on the view:

- that illegal drug trafficking is a criminal offence, but not drug consumption;
- that DUD are health disorders in need of treatment and not punishment;
- that in the first and minor offences by PWDUD the principle "treatment rather than punishment" should be applied and imprisonment applied only as a last resort;
- that prisons are not the best place for treatment of DUD.

In addition, incarceration of PWDUD has been shown to considerably increase the risk of spreading transmittable diseases in prison and to the community[6] as a consequence of the temporary concentration of people with risk behaviour for transmission of diseases in an environment where preventive and therapeutic measures are often scarce or lacking, and who eventually return to the community.

Therefore, legal provisions for non-custodial sanction measures for offenders with DUD should be in place, such as diversion by warnings, mediations, fines, restorative justice and referral to treatment. Organisational structures and resources for probation services and community sanctions should be established or strengthened. Sentencing practices for DUD offenders should resort to these structures to the maximum extent possible and, likewise, application of pre-trial detention should be reduced to the minimum extent possible, which may need awareness raising in and training of judges. In addition, sentencing to these alternative, non-custodial measures should be exempted from inclusion on criminal records in order to avoid unintended negative consequences for future resocialisation and social rehabilitation of PWDUD.[7] There is ample international support and guidance that establishes such legal provisions, structures and practices.[8, 9, 10, 11, 12, 13]

For healthcare and treatment of PWDUD in prison, healthcare governance in prison may play a crucial role with regard to the professional independence of healthcare providers, a cornerstone of high-quality healthcare in prison. In addition to legal guarantees for clinical independence, healthcare governance that is removed from the jurisdiction of penitentiary administrations and transferred to prison health departments subordinated directly to the ministry of justice, or transferred to the ministry of health or public health authorities, increases the clinical independence of healthcare providers from penitentiary administrations. A majority of European jurisdictions have legally and administratively undertaken these transfers in the last few decades.[14] However, if the responsibility for the health of persons in the criminal justice system is transferred to the ministry of health, their health needs must not be given less priority than that of the community.

6. Dolan K. et al. (2016), "Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees", *Lancet* 388 (10049), pp. 1089-1102, available at http://dx.doi.org/10.1016/S0140-6736(16)30466-4 and Altice F.L. et al. (2016), "The perfect storm: incarceration and the high-risk environment perpetuating transmission of HIV, hepatitis C virus, and tuberculosis in Eastern Europe and Central Asia", *Lancet* 388 (10050), pp. 1228-48, available at http://dx.doi.org/10.1016/S0140-6736(16)30856-X, both accessed 31 October 2022.
7. Bretteville-Jensen A.L. et al. (2017), "Costs and unintended consequences of drug use control policies", Pompidou Group, Council of Europe, Strasbourg, available at https://rm.coe.int/costs-and-unitended-consequences-of-drug-control-policies/16807701a9, accessed 31 October 2022.
8. Recommendation CM/Rec(2017)3 on the European Rules on community sanctions and measures; Recommendation CM/Rec(2014)4 on electronic monitoring; Recommendation Rec(2003)22 on conditional release (parole). All available at https://rm.coe.int/compendium-e-2020-final/16809f3927, accessed 31 October 2022.
9. United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), available at www.ohchr.org/Documents/ProfessionalInterest/tokyorules.pdf, accessed 31 October 2022.
10. Recommendation CM/Rec(2017)3 of the Committee of Ministers on the European Rules on community sanctions and measures, available at https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680700a5a, accessed 31 October 2022.
11. Geiran V. and Durnescu I. (2019), "Implementing community sanctions and measures", Council of Europe, Strasbourg, available at https://rm.coe.int/implementing-community-sanctions-and-measures/1680995098, accessed 31 October 2022.
12. Heard C. and Fair H. (2019), "Pre-trial detention and its over-use. Evidence from ten countries", Institute for Crime & Justice Policy Research, London, available at https://prisonstudies.org/sites/default/files/resources/downloads/pre-trial_detention_final.pdf, accessed 31 October 2022.
13. European Union (2019), "Council conclusions on alternative measures to detention: the use of non-custodial sanctions and measures in the field of criminal justice", *Official Journal of the European Union* 2019/C422/06, available at https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52019XG1216(02), accessed 31 October 2022.
14. Pont J. and Harding T.W. (2019), "Organisation and management of healthcare in prison. Guidelines", Council of Europe, Strasbourg, available at https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69, accessed 31 October 2022.

Appropriate legal regulations are also required for enabling internationally recognised and recommended[15] harm reduction and treatment measures for PWDUD in prison such as access to condoms and lubricants, needle/syringe exchange programmes and permission for opioid agonist treatment (OAT) in prison for programmes of medication for opioid use disorder (MOUD).

In the case law of the European Court of Human Rights, the international court of the Council of Europe, applications alleging that a contracting state has breached human rights according to the European Convention on Human Rights, specifically Article 2 (right to life) and Article 3 (prohibition of torture), have been identified. Subsequently, member states have been found to be guilty of a lack or inadequate treatment of PWDUD in prison (e.g. *Keenan v. the United Kingdom*, *Mouisel v. France*, *Kats and Others v. Ukraine*, *McGlinchey and Others v. the United Kingdom* and *Wenner v. Germany*).[16]

The recommendations of the Expert Group on the regulatory framework for the treatment of opioid dependence syndrome and the prescription of opioid agonist medicines[17] included the prescription and delivery of opioid agonists without prior authorisation schemes, the effective removal of financial barriers for patients undergoing treatment and the set-up of a national consultative body for co-ordination and monitoring, measures that definitely require the adaptation of legal frameworks, particularly for MOUD in custodial settings.

Recent research on naloxone administration by laypersons in life-threatening opioid overdose cases gives reason to consider legally permitting this potentially life-saving medicine to be administered by non-medical custodial staff during imprisonment and by laypersons after release from prison when no health professionals are present during opioid overdose emergencies.[18]

Ethics standards

Treatment for PWDUD is healthcare. Therefore, the principles of medical ethics apply to treatment of PWDUD. There is a body of internationally consented principles of medical ethics specified for healthcare in prison (enshrined in the documents listed in the literature review at the end of this document). The sole task of healthcare providers in prison is the health and well-being of inmates, and the essence of the healthcare provided can be summarised as follows:

- free access for every prisoner;
- equivalence of and integration with community healthcare;
- involving patient consent and confidentiality;
- comprising preventive healthcare;
- comprising humanitarian assistance;
- professionally independent;
- professionally competent.

It is important that prison healthcare workers stick to these principles but also that they are made known to and accepted by the whole prison community, that is the PDL, the staff and the prison administration. With regard to treatment of PWDUD, prison administrations and non-medical staff, if not adequately informed on the evidenced benefits, may resist or counteract treatment while focusing on the risks of misuse, such as the prescription of opioid agonists in MOUD.

Specifying that the sole task of healthcare providers in prison is the health and well-being of inmates implies that they are not to be involved in custodial measures such as drug testing for security reasons, body searches or any disciplinary measures. It also implies that in the treatment of PWDUD the treatment goals agreed on with the patient – both for the short and long run – are achievable for the individual patient and should not be swayed by the treatment provider's own ideas on human dignity and lifestyle. It is the health and well-being

15. UNODC/ILO/UNDP/WHO/UNAIDS (2013), "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions", Policy Brief, United Nations Office on Drugs and Crime, available at www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf, accessed 31 October 2022.
16. Council of Europe/European Court of Human Rights (2021), "Guide on the case-law of the European Convention on Human Rights. Prisoners' rights", updated April 2021, Council of Europe, Strasbourg, available at www.echr.coe.int/Documents/Guide_Prisoners_rights_ENG.pdf, accessed 31 October 2022.
17. Pompidou Group (2017), "Opioid agonist treatment. Guiding principles for legislation and regulations", Council of Europe, Strasbourg, available at https://rm.coe.int/2017-ppg-15-oat-guidingprinciples-final-eng/16808b6d9e, accessed 31 October 2022.
18. NCCHC (2020), "Naloxone in correctional facilities for the prevention of opioid overdose deaths", National Commission of Correctional Health Care, available at www.ncchc.org/naloxone-in-correctional-facilities-for-the-prevention-of-opioid-overdose-deaths-2020, accessed 31 October 2022.

of the inmate patient that is the task of therapy, and not necessarily an adjustment of the patient's way of life to one that conforms to the therapist's notions.

The next two of the above listed principles, Free access to healthcare and equivalence of and integration with community healthcare indicate the access of imprisoned PWDUD to the same treatment and harm reduction options as those that are accessible in the community, namely staffing or contracting properly trained therapists for DUD, state-of-the-art treatment and harm reduction programmes in prison, and identifying PWDUD on admission and offering them the available programmes. Equivalence and integration of treatment and harm reduction programmes is also a safeguard for the indispensable continuity of care between prison and the community.

Equal access to treatment should be available for females with DUD in prison. Due to the low numbers of female PDL in comparison to males, in many countries far fewer services and treatment offers exist for females. Given their comparatively greater physical and mental co-morbidities and their higher HIV prevalence rates, females with DUD in prison may need even more treatment options than their male counterparts.

The crucial principles of patient consent and medical confidentiality play a major role in treatment of DUD. Consent of the adequately informed patient – "informed consent" – is a prerequisite to any treatment. There is no place for compulsory treatment of PWDUD because this amounts to a violation of human rights and has been shown to lack efficacy.[19, 20, 21]

Before entering a patient into a DUD treatment programme, the minimum information required may include:

- any obligation the physician has towards a third party that impairs confidentiality (notification to the authorities according to the law or courts), but also all those areas where the patient can count on strict medical confidentiality;
- the rationale of the DUD treatment;
- the obligations of the patient and the therapist as agreed;
- the individual current treatment goal as elaborated with the patient;
- risks, unwanted side effects and possible restraints;
- what is likely to happen if the patient deliberately stops treatment;
- how to deal with relapses;
- what might cause the termination of participation in the treatment.

Treatment programmes that are complex in medical, legal and psychological terms, such as MOUD, often do not only rely on the verbal or written informed consent of the patient, but require a formal contract to be signed by the patient and the therapist. While a contract might suggest elements of coercion and generate mistrust in the patient-physician relationship, it underlines the agreed-on obligations of patient and therapist, which can be used to remind both parties of or demand these obligations. If they are explained and discussed properly, they can enhance understanding of the treatment programme.

Medical confidentiality is not only a principle of medical ethics, it is a prerequisite for building trust in the patient-health professional relationship. PWDUD in prison may want to conceal their substance use issues for several reasons: they anticipate disadvantages in terms of placement, privileges and access to work; and they fear prejudice and discrimination both by inmates and by staff, as they can become victims of pressure and blackmail as soon as their drug dependence is known to others. For example, when participating in OAT programmes, they may be pressured to divert the prescribed drugs to the black market in prison. For these reasons, every endeavour should be made to protect PWDUD in prison by maintaining good standards of confidentiality and by dismantling discriminatory regulations, behaviours and attitudes against them.

However, confidentiality for PWDUD in prison may be limited for legal and practical reasons: for instance, national laws often require notification of persons who are prescribed opioids and the supply and delivery of opiate agonist drugs, especially given the shortage of medical staff, often requires the inclusion of and co-operation with security officers, a measure that impedes strict medical confidentiality. Comprehensive treatment of DUD in prison needs interdisciplinary co-operation, where sharing of information and records is unavoidable and often in the interest of the patient. However, as a rule every member of the treatment team

19. Stevens A. (2012), "The ethics and effectiveness of coerced treatment of people who use drugs", *Human Rights and Drugs* 2, pp. 7-15.
20. Werb D. et al. (2016), "The effectiveness of compulsory drug treatment: a systematic review", *International Journal of Drug Policy* 28, pp. 1-9.
21. Lunze K. et al. (2016), "Mandatory addiction treatment for people who use drugs: global health and human rights analysis", *British Medical Journal* i2943.

should be bound by professional confidentiality. It is of great importance that patients are well informed as to who will have access to their records, who is included in professional confidentiality and where the *de facto* limitations of confidentiality are.

As for preventive healthcare, treatment of DUD and harm reduction strategies represent classical examples of an effective prevention and harm reduction measure for PWDUD as well as for society inside and outside prison walls: the abundant evidence on prevention of mortality, morbidity, personal suffering, social instability and criminal activity is well documented and the preventive impact on HIV and hepatitis B and C transmission by reducing high-risk drug-injecting behaviour in prison, particularly through MOUD, is evident. Preventive healthcare for PWDUD includes arrangements for continuity of treatment after release from prison and prevention of the excessive rate of mortality immediately after release from prison.

Protective care for PWDUD by healthcare professionals relates to their particular vulnerability in prison: they rank low in the prisoner hierarchy, face the prejudice of inmates and staff, and run the risk of getting into debt, with subsequent threats of bullying, violence, coercive sex work and pressure to divert prescribed drugs. A considerable proportion of PWDUD suffer from additional mental disorders ("dual diagnosis") and need additional treatment, care and protection. Some of these problems can be avoided by confidentiality and providing appropriate treatment of their DUD but often sensible placement changes and additional protective measures may become necessary. Additional care and protection are also required for female and juvenile persons with DUD and for pregnancy and perinatal care of women with DUD. For pregnant women, mothers with young children, juveniles and children with DUD, imprisonment should be the very last resort and all non-custodial measures available should be exhausted. The UNODC/WHO publication *International standards for the treatment of drug use disorders* contains chapters on PWDUD with special treatment and care needs for these groups, including specificities on medication-assisted psychosocial treatment. In adolescents, a higher co-morbidity of mental disorders than in adults must be taken into account. While there is good evidence of age-appropriate psychosocial treatment in adolescents, there is very limited evidence of psychosocial and medication-assisted treatment (MAT) in younger children.

A vitally important part of the treatment of PWDUD in prison is the absolute professional clinical independence of healthcare providers. All clinical decisions on the indications for treatment, the type and duration of treatment, the type and dosage of medication treatment and so on should only be taken by the responsible healthcare professional based on an individual assessment of the patient and mutual agreement, and should not be overruled or ignored by non-medical prison staff. Treatment for DUD in prison is a medical treatment independent of custodial measures. This clarification is particularly important for those patients who have been sentenced by the courts to undergo treatment for addiction while serving their prison term.

Treatment of PWDUD in prison also requires the professional competence of all care providers involved: primary healthcare (PHC) providers should be trained in screening and identifying PWDUD upon admission to prison to treat withdrawal syndrome, to inform them about risks and available harm reduction and treatment programmes, and to screen for somatic and mental co-morbidities. PHC providers should also have a basic knowledge on identifying mental disorders, including DUD, in order to arrange specialised (secondary) care for PWDUD and other mental health disorders. They should be supported by clinical psychologists, psychiatrists, and DUD therapists and social workers trained in the treatment and psychosocial care of PWDUD. Many prisons are not sufficiently staffed with these professional profiles and competencies, so support should be sought by contracting civilian services and non-governmental organisations (NGOs) experienced in the treatment and care of PWDUD. However, custodial staff should also, in their initial and continuous training, be taught about the basics of current concepts regarding DUD and related treatment in order to understand and support these concepts. Development of training curricula for the various professional profiles and associated guidelines should support professional competence.

Treatment services and interventions

The UNODC/WHO Standards, based on currently available scientific evidence of ethical treatment for DUD, set out a framework in line with principles of public healthcare that match the needs of PWDUD at all stages and severities of DUD, consistent with the treatment of any chronic disease or health disorder. The standards maintain a degree of flexibility to ensure their applicability in different social, cultural and legal frameworks, including custodial settings, the specificities of which a chapter is dedicated to. The standards are aspirational, and as such, national or local treatment services or systems need not attempt to meet them all at once. However, over time, progressive quality improvement, with evidence-based and ethical practice as an objective, can and should be expected to achieve better organised, more effective and ethical systems and services for PWDUD.

Key aspects for the treatment of PWDUD should be:

- effective: evidence-based, according to scientific standards;
- ethical, meaning it should:
  - be consistent with human rights and UN covenants;
  - promote individual and social safety;
  - promote personal autonomy;
  - build on existing experience and standards.

Treatment methods include:

- psychosocial therapy;
- pharmacotherapy;
- pharmacotherapy-assisted psychosocial therapy.

Goals of treatment should be to:

- reduce demand for and use of psychoactive drugs;
- improve health and psychosocial functioning;
- prevent or reduce harm.

Modalities of treatment programmes should be:

- available, accessible, attractive, appropriate and affordable;
- legally protected and ethically sound (including consent, confidentiality, clinical independence);
- under clinical governance, with protocols on training, staffing, recording and networking;
- co-ordinated between the criminal justice system and health and social services;
- adapted to individual needs and the needs of subgroups (e.g. women, juveniles, minorities);
- monitored, evaluated and quality controlled.

Treatment services and interventions in the criminal justice system

Whenever the liberty of people is taken away by the various levels of the criminal justice system, that is through police detention, prosecution hearings, pre-trial detention, court hearings and imprisonment, they should, as a standard, be screened for DUD. Screening should pay attention to any immediate treatment requirements such as withdrawal symptoms, intoxication, acute mental disorders or suicidality, but also consider at each level for PWDUD non-custodial measures and treatment rather than imprisonment whenever possible.

Treatment and interventions for PWDUD in prison raise the question of sufficient availability and qualification of treatment providers in penitentiary institution as well as a co-requisite therapeutic environment. In keeping with providing equivalence of care, if medically indicated treatments for PWDUD are not possible or available in prison, the individual must be referred to the appropriate medical services outside the institution. This applies both to psychosocial treatment interventions and to MAT, such as OAT in withdrawal or maintenance therapy for people with opioid use disorder (OUD).

Staffing of adequately trained therapists for PWDUD is rarely, if ever, sufficient in penitentiary systems and contracting trained therapists is inevitable. Quality of treatment for PWDUD is not dependent on the affiliation of therapists but on their level of qualification.

PWDUD undergoing treatment programmes in prison should ideally be separated from other inmates to reduce their risk of being exposed to drugs and relapse, to reduce their risk of becoming victimised and to maintain a therapeutic environment. Residential treatment such as therapeutic communities (TCs) needs to be conducted in dedicated units within the prison.

Standards of treatment and interventions by primary healthcare professionals in prison

Although not specifically trained in the treatment of PWDUD, PHC professionals play a central role in their care in prison. In general terms, their professional ethics should provide a guarantee for an ethical framework and

professional approach towards the care and treatment of PWDUD in the same way as for any other patients with a chronic health disorder, including advocacy for and supervision of preventive and harm reduction measures.

PHC physicians need to be trained in screening for and identifying PWDUD upon admission and possible immediate need of treatment, including frequently occurring mental and physical co-morbidities, in order to arrange for immediate interventions such as treatment of withdrawal symptoms and prevention of self-harm and suicide, and for referral to specialised treatment such as psychiatric care and treatment of infectious diseases. PHC physicians in prisons not specialised in treatment for PWDUD still can and should engage in Screening, Brief Interventions and Referral to Treatment (SBIRT) of PWDUD according to the WHO/UNODC standards for the treatment of drug use disorders.

The screening for and identification of DUD in persons newly admitted to prison is the decisive prerequisite for all further steps of specific care and treatment of PWDUD, who may try to hide their disorder fearing negative consequences, stigma, discrimination and victimisation during imprisonment. The medical examination upon admission by the PHC professional should be accompanied by an assurance of full confidentiality and patient's consent, privacy of the examination, and building up of trust for a sound patient/caregiver relationship in order to obtain truthful patient histories. In addition, simple screening tools such as the WHO ASSIST screening test[22] may be used.

A brief intervention is a short, structured psychotherapy to be applied by general practitioners following relatively little training to PWDUD, with the aim to empower and motivate them to take responsibility and change their substance use behaviour.[23] It follows a client-centred approach drawing on their strengths to help them reflect and develop the skills and resources required to change. Realistic goals are set, positive feedback is provided to the patient and they are assessed to see if further treatment is required. The components of effective brief interventions can be summarised through the FRAMES framework: Feedback is given to the individual about personal risk or impairment; Responsibility for change is given to the individual; Advice to change is given by the provider; a Menu of alternative self-help or treatment options is offered; an Empathic style is used in counselling; Self-efficacy or optimistic empowerment is engendered. A brief intervention typically does not take more than 30 minutes.

Referral by the PHC physician to specialised treatment should occur whenever there is an insufficient response to a brief intervention or a clinically significant DUD or co-morbid mental or physical health condition requiring specialised treatment becomes apparent.

In some penitentiary systems, general practitioners in prison have been trained to conduct OAT for patients with opioid drug use disorders under the guidance and supervision of specialists in the treatment of PWDUD, particularly as DUD specialists are not continuously available and OAT has been shown to be effective even without accompanying psychosocial therapy. However, whereas a brief intervention requires comparatively little training for general practitioners, the complexity of OAT demands thorough training and a licensing process.

PHC professionals must be trained and equipped to manage the medical emergencies of PWDUD upon admission and thereafter, such as psychoactive drug withdrawal syndromes and intoxication, acute mental health disorder exacerbations and suicidality. The PHC unit of a prison should function according to the "one-stop-shop" approach for PWDUD: besides general healthcare provision and preventive services such as vaccinations, harm reduction provisions, delivery and supervision of medication for co-morbid conditions including HIV disease, hepatitis B and C, TB, mental disorders and MOUD if required, and recognition and response to health crisis situations, it should serve as a gatekeeper to specialised services such as psychological and psychiatric care, infection specialists, and social assistance and protection. The PHC unit is also the place where the treatment documentation of PWDUD is kept, as part of their confidential, individual medical record.

Standards of treatment by specialists in the treatment of people with drug use disorders

Specialised care services for PWDUD in prison – including medical, psychological, psychotherapeutic, social and educational care – must only be administered by personnel with the relevant qualifications and licences. If not available in prison, they must be contracted or delivered by civilian public or NGO facilities. Typically, they are either carried out by health and social care professionals specialised in the treatment of DUD, or

22. Available at www.who.int/publications/i/item/the-who-assist-package-for-hazardous-and-harmful-substance-use , accessed 31 October 2022.
23. Miller W.R. and Rollnick S. (2002), *Motivational interviewing: preparing people for change* (2nd edn), Guilford Press, New York.

more broadly within the context of mental health treatment, and consist of a combination of psychosocial and pharmacological interventions.

Any specialised treatment of PWDUD in prison should start with a thorough diagnostic assessment of the individual DUD patient, evaluating the severity of drug and other substance use disorders and associated problems (including psychiatric, physical health and family issues). Useful evaluation instruments are the Addiction Severity Index (ASI),[24] the Mini-International Neuropsychiatric Interview (MINI)[25] and the Composite International Diagnostic Interview-Substance Abuse Module (CIDI-SAM).[26] Based on the professional individual assessment of each patient, an individualised treatment plan needs to be elaborated with the patient, to be regularly revised in the course of treatment.

Evidence-based psychosocial treatment

Evidence-based psychosocial treatments address motivational, behavioural, psychological and social factors and have been shown to reduce drug use, minimise associated risks, increase adherence to treatment, prevent relapse and promote abstinence.

Evidence-based psychological interventions that can be applied in custodial settings include:

- cognitive behavioural therapy;
- motivational interviewing;
- motivational enhancement therapy;
- contingency management;
- community reinforcement approach;
- mutual help groups (including 12-step groups);
- TCs.

Cognitive behavioural therapy aims to modify learned drug use patterns and induces PWDUD to develop new scoping skills and cognitive strategies for replacing dysfunctional behaviour and thinking through structured sessions with specific achievable goals in individual or group therapy.

Motivational interviewing and motivational enhancement therapy comprise treatment techniques that recognise the patient's autonomy and own values, and build a therapeutic alliance through empathy, with the therapist's role advisory rather than authoritative.

Contingency management is a therapeutic strategy that applies rewards to reinforce positive behaviour and treatment goals such as compliance and abstinence. It is often combined with cognitive behavioural therapy and monitored with drug testing for feedback.

Community reinforcement approaches and mutual help groups generally belong to long-term treatment strategies that in prisons can be used in TCs. PWDUD in TCs in prison stay in a dedicated section of a prison with strict rules where they participate in an intensive daily programme of group work and community meetings aiming at mutual aid and self-help, active participation in community life, and gaining life skills and vocational training. Traditional models of long-term residential treatment included strict abstinence and only psychosocial treatment methods, whereas modern approaches may involve the use of medication to decrease drug cravings and manage co-morbid psychiatric symptoms. Indispensable requirements for TCs in prison are the absolute informed consent of participants, management by licensed specialists for treatment of DUD and professional medical supervision, preferably by a psychiatrist.[27]

The selection of treatment techniques offered may depend on the assessment of the severity of the DUD, the pattern of psychoactive drugs consumed, and the availability and training of specialised therapists for PWDUD.

24. McLellan A.T. et al. (1980), "An improved diagnostic evaluation instrument for substance abuse patients. The Addiction Severity Index", *The Journal of Nervous and Mental Disease* 168, pp. 26-33, available at https://pubmed.ncbi.nlm.nih.gov/7351540, accessed 31 October 2022.
25. Sheehan D.V. et al. (1998), "The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10", *The Journal of Clinical Psychiatry* 59 Suppl 20, pp. 22-33;quiz 34-57, available at https://pubmed.ncbi.nlm.nih.gov/9881538, accessed 31 October 2022.
26. Cottler L.B., Robins L.N. and Helzer J.E. (1989), "The reliability of the CIDI-SAM: a comprehensive substance abuse interview", *British Journal of Addiction* 84, pp. 801-14, available at https://pubmed.ncbi.nlm.nih.gov/2758153/, accessed 31 October 2022.
27. EMCDDA (2014), "Therapeutic communities for treating addictions in Europe. Evidence, current practices and future challenges", European Monitoring Centre for Drugs and Drug Addiction, available at www.emcdda.europa.eu/system/files/publications/779/TDXD14015ENN_final_467020.pdf, accessed 31 October 2022.

Less severe disorders may be treated sufficiently with short-term interventions, whereas severe disorders may need long-term treatment; OUD are best are treated with MAT whereas stimulant use disorders have been shown to benefit more from contingency management. Therapists may use one or other of the listed techniques depending on their experience or may combine several techniques. The shortage of therapists in relation to patients in need of treatment and considerations of cost efficiency may lead to conduct group treatment rather than individual sessions.

The minimum standards for psychosocial treatment by specialists in treatment of PWDUD include the absolute informed consent of participants; sufficient availability, training and licensing of therapists; availability of appropriate premises for group therapy as well as confidential individual therapy; and thorough, confidential documentation and evaluation and quality control of all therapeutic activities.

Evidence-based pharmacological treatment

Evidence-based pharmacotherapy for PWDUD includes treatment for symptoms of psychoactive drug withdrawal, maintenance treatment for people with OUD, emergency treatment of overdose intoxication, and pharmacological treatment of all mental and physical co-morbidities.

Withdrawal from psychoactive drugs without medical treatment can cause severe suffering and, particularly in acute withdrawal from benzodiazepines and alcohol, life-threatening conditions in need of hospital care. Not offering MAT amounts to malpractice and a human rights violation.

Standard treatment for withdrawal of opioids is tapering medication of long-acting opioid agonists such as methadone or buprenorphine over at least 2 weeks, or tapering doses of alpha-2-adrenergic agonists. For benzodiazepine and alcohol withdrawal syndromes, close monitoring and long-acting benzodiazepines in tapering doses no longer than two weeks is the standard.

Medication for withdrawal syndromes of stimulants (amphetamine and cocaine), cannabinoids (if occurring at all) and the many new psychoactive substances (NPS) are less well defined and limited to symptomatic treatment. Any medical withdrawal management should be accompanied by psychosocial support. The rapidly increasing number of NPS and their often ill-defined pharmacological actions, toxicities and dependency hazards cause considerable problems in identifying, diagnosing and treating users. The most frequently found substances in prisons consist of synthetic cannabinoids, synthetic cathinones, new synthetic opioids and new benzodiazepines.[28] Their partially overlapping action profiles categorise them as depressants, stimulants or hallucinogens. Psychosocial treatment of DUD with NPS use does not differ from DUD with other psychoactive substances. Treatment of withdrawal from or intoxication with NPS is limited to symptomatic treatment and there is no evidence for any specific MAT. Detailed information can be gathered from the NEPTUNE (Novel Psychoactive Treatment UK Network) *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances*. [29]

Maintenance treatment for OUD with opioid agonists, earlier known as opioid substitution treatment (OST) and now generally named OAT, or MAT of opioid disorders or MOUD, plays a major role because it has been proven to be the most effective treatment option for OUD in terms of reduction of mortality, reduction of transmission rates of blood-borne infections (HIV, hepatitis B and C), reduction of rates of criminal re-offending, and improvement of social and occupational functioning.

Standard MOUD comprises prescribed medication of oral long-acting opioid agonists such as methadone and buprenorphine, although slow-release morphine and even injectable heroin under medical prescription and supervision has also been shown to be effective. Methadone and buprenorphine for treatment of OUD have been included in the WHO Model List of Essential Medicines. The commencement, maintenance and termination of MOUD require close supervision by therapists trained in MOUD so as to avoid too low doses that can provoke relapses, to avoid overdoses leading to intoxication, and to restrict avoidance of diversion and misuse of the medication, particularly in custodial settings. MOUD should be combined with psychosocial treatment as much as possible; however, it has been shown to be effective even without psychosocial support, whereas psychosocial treatment of persons with OUD without MOUD has been shown to be less

28. EMCDDA (2018), *New psychoactive substances in prison*, European Monitoring Centre for Drugs and Drug Addiction, available at www.emcdda.europa.eu/publications/rapid-communications/nps-in-prison_en, accessed 31 October 2022.
29. NEPTUNE (2015), *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances*, Novel Psychoactive Treatment UK Network, available at http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf, accessed 31 October 2022.

effective. There is ample literature on the details and feasibility of MOUD in prisons, as listed in section C) of the Literature Review at the end of this document.

OAT with the opioid antagonist naltrexone, for prevention of relapse in patients who have abstained from opioids for longer than a week and who are highly motivated to remain abstinent, is a treatment option less well documented than OAT in terms of effectiveness.

As there is no evidence-based medication treatment for DUD with stimulants (amphetamine, cocaine), cannabinoids or sedatives (benzodiazepines) apart from withdrawal management as described above, treatment for these DUD is limited to psychosocial interventions.

An important and potentially life-saving pharmacological intervention is the application of the opioid antagonist naloxone in opioid intoxication. Naloxone, injected or nasally applied, reverses the effects of opioids on its receptors, including the life-threatening respiratory depression in opioid overdosing, within minutes. Therefore, naloxone has been included in the WHO Model List of Essential Medicines; it always should be available together with resuscitation equipment in the medical emergency box of each prison. Take-home programmes of naloxone along with corresponding information and training have been shown to reduce the excessive rate of opioid overdose-related deaths in the first days after release of PWDUD from prisons.[30]

The numerous co-morbidities of PWDUD require the availability and professional pharmaceutical stocking of medication for mental disorders, including last generation neuroleptic and antidepressant drugs, up-to-date medication for HIV, chronic hepatitis B and C, and tuberculosis, to be prescribed by specialised physicians aware of the pharmacological interaction within these groups of medication and with prescribed opioids.

Minimum standards for pharmacological treatment of PWDUD in prisons are the availability of state-of-the-art medication for withdrawal syndromes, opioid maintenance treatment and all mental and physical co-morbidities, delivered by trained therapists supported by psychosocial therapy and preparedness for state-of-the- art treatment of drug-related emergencies.

Continuity of care for people with drug use disorders

DUD, like any other chronic health condition, require continuity of care for optimal treatment outcomes. PWDUD in contact with the criminal justice system face risks of interruptions of treatment and care when undergoing criminal justice measures, which can seriously impair their health. Although many PWDUD undergo care and treatment for their DUD for the first time when they are imprisoned, others may have been on long-term treatment such as MOUD in community facilities and experience interruption of their treatment when in police custody or imprisoned or transferred to institutions where OAT is not available, resulting in withdrawal syndrome, loss of opioid tolerance and risk of intoxication. Thus, there is a need for a joined-up approach with civilian services caring for PWDUD and the police detention and criminal justice system to ensure continuity of care.

The preparation of PWDUD for release, including co-ordination with civilian public services and NGOs caring for PWDUD, is of utmost importance for the seamless continuation of care in the most critical phase after release from prison, in terms of psychosocial support for housing, occupation and social integration and prevention of re-offending, but also in terms of saving lives. The excessively high mortality rate of PWDUD following release can be considerably reduced by proper information on the loss of opioid tolerance in people with OUD, uninterrupted continuation of MOUD after release and naloxone take-home programmes.[23, 31]

30. WHO (2014), "Preventing overdose deaths in the criminal-justice system", World Health Organization, available at www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf, accessed 31 October 2022.
31. Marsden, J. et al. (2017), "Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England", *Addiction* 112, pp. 1408-18.

Recommendations

Legal framework

1. Review penal law with regard to compliance with international recommendations and human rights standards in view of sentencing practices and availability of alternative sanctions for PWDUD.

2. Provide legal provisions for diversion, warnings, mediation, fines, restorative justice and referral to treatment for offenders with DUD at all levels of the criminal justice system.

3. Establish or strengthen organisational structures and resources for probation services and community sanctions.

4. Advocate sentencing practices for PWDUD offenders to non-custodial measures and avoidance of pre-trial detention whenever possible and provide awareness raising and training of judges in this regard.

5. Consider transitioning authority over prison healthcare away from penitentiary administrations to specialised services within the ministry of justice or the ministry of health or other public health authorities.

6. Provide legal provisions and other regulatory frameworks that allow internationally recommended harm reduction and treatment measures for PWDUD in prison, such as OAT as part of MOUD and all other interventions recommended by WHO, UNODC[32] and the expert group on OAT.[33]

7. Consider the legal permission of naloxone administration and injection by laypersons and non-medical custodial staff in life-threatening opioid overdose cases.

Ethical standards

8. Ethics in treatment of PWDUD is to be based on the internationally consented principles on healthcare ethics in prison, and the whole prison community should be aware of and accept these principles.

9. End involvement of healthcare staff in any custodial and disciplinary punishment measures and remove any influence of non-medical staff on clinical decisions by healthcare staff.

10. Integrate treatment and harm reduction programmes for PWDUD in prison with those available in the community to the greatest possible extent.

11. Provide free access of PWDUD to treatment and harm reduction measures equivalent to those available in the community, ensuring that women can access treatment that is at least equivalent to that for men.

12. Provide sufficient staffing or contracting of trained therapists for PWDUD in prisons.

13. Stipulate fully informed consent for treatment of PWDUD and abandon compulsory treatment of PWDUD.

14. Ensure medical confidentiality in treatment of PWDUD to the greatest possible extent.

15. Implement a concept that ensures continuity of care after release through information sharing and co-operation with health services, including the availability of take-home naloxone programmes upon release from prison to prevent mortality.

32. Pont J. and Harding T.W. (2019), "Organisation and management of health care in prison. Guidelines", Council of Europe, Strasbourg, available at https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69, accessed 31 October 2022.

33. "Guide on the case-law of the European Convention on Human Rights. Prisoners' rights", updated April 2021, available at www.echr.coe.int/Documents/Guide_Prisoners_rights_ENG.pdf, accessed 31 October 2022.

16. Consider the needs of particularly vulnerable groups among those in treatment, such as people with additional mental disorders, women and juveniles with DUD.

17. Stipulate the absolute professional clinical independence of healthcare professionals providing treatment for PWDUD

18. Request high levels of professional competence and continuous training of all those involved in the treatment and care of PWDUD and support them by developing training curricula and guidelines.

Treatment services and interventions

19. Review and adapt human resources for adequate care and treatment services for PWDUD in the criminal justice system

20. Review and adapt premises in prisons for adequate care and treatment of PWDUD.

21. Review and adapt co-operation/contracts with civilian public and NGO facilities for the care and treatment of PWDUD in prison.

22. Review and update continued training and guidelines for all criminal justice personnel involved in decisions on and implementation of treatment and care of PWDUD.

23. Train primary care physicians in screening for and identifying PWDUD upon admission for immediately needed interventions, assessment of risks and co-morbidities, and referral to specialised services if needed.

24. Consider specialised training and licensing of primary care physicians in prisons on OAT and training for screening of DUD upon admission.

25. Equip and maintain PHC units with medication and resuscitation devices for drug-related emergencies.

26. To meet the need for specialised treatment services for PWDUD in prison, obtain an overview of the availability of therapists experienced in current evidence-based standards of treatment of PWDUD within and outside the prison system, and the training capacity for future drug therapists in co-operation with civilian public agencies and NGOs.

27. Plan the structured and cost-efficient operation of specialised psychosocial interventions for short-term and long-term therapy for PWDUD in prison according to their availability and patients' needs.

28. Provide the availability and professional pharmaceutical management and control of MAT for OUD, that is opioid agonists such as methadone and buprenorphine for MAT of withdrawal syndromes, within the framework of the quality control and continuous evaluation of clearly defined OAT programmes in prison.

29. Arrange for specialised care and treatment of the psychiatric and physical co-morbidities of PWDUD through consultation and referral to the appropriate specialists and specialist facilities.

30. Arrange for continuity of care and treatment of PWDUD through the uninterrupted treatment of those who have been under treatment prior to imprisonment, through a joined-up approach with civilian services caring for PWDUD and the police detention and criminal justice system.

31. Arrange for continuity of care and treatment of PWDUD upon release through close co-operation with civilian public or NGO agencies involved in the care of PWDUD, and prevention of intoxication-related deaths following release by proper information on imprisonment-induced loss of tolerance and uninterrupted continuation of MOUD.

32. Consider the implementation of naloxone take-home programmes upon release from prison for persons with OUD.

Literature Review

To address the development of comprehensive treatment systems for PDL with psychoactive DUD in prison, the author includes in A) documents containing the standards and principles of healthcare in prison, which also serve as a basis for the treatment of persons with psychoactive DUD. Likewise, in keeping with the principles of equivalence of care, B) contains documents on the international standards and principles for treatment of all people with psychoactive DUD, including chapters focusing on treatment in prison. C) focuses on documents on the standards and principles of treatment of PWDUD in prison.[34]

A. International standards and principles of providing healthcare in prison

Council of Europe[35]

Recommendation CM/Rec(2017)3 on the European Rules on community sanctions and measures

Recommendation CM/Rec(2014)4 on electronic monitoring

Recommendation Rec(2003)22 on conditional release (parole)

Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison

Recommendation No. R (93) 6 concerning prison and criminological aspects of the control of transmissible diseases including Aids and related health problems in prison

European Prison Rules:

- Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules
- Commentary on Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules
- Revision of the European Prison Rules, a contextual report, 2006
- Recommendation Rec(2006)2-rev, 2020
  https://search.coe.int/cm/Pages/result_details.aspx?ObjectId=09000016809ee581

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (1993), "Health care services in prisons", CPT/Inf(93)12-part, Extract from the 3rd General Report of the CPT, available at https://rm.coe.int/16806ce943.

Lehtmets A. and Pont J. (2014), *Prison health care and medical ethics*, Council of Europe Publishing, Strasbourg, available at https://book.coe.int/en/penal-law-and-criminology/6882-pdf-prison-health-care-and-medical-ethics.html#.

Pont J. and Harding T. (2019), "Organisation and management of health care in prison", Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69.

United Nations

Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by General Assembly resolution 37/194 of 18 December 1982, available at www.cirp.org/library/ethics/UN-medical-ethics.

34. All linked documents in the literature review were accessed on 3 November 2022.
35. All Council of Europe Recommendations are available at https://rm.coe.int/compendium-e-2020-final/16809f3927, accessed 31 October 2022.

United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Resolution adopted by the General Assembly on 17 December 2015, available at https://undocs.org/A/RES/70/175.

UNODC/WHO (2013), "Good governance of prison health in the 21st century. A policy brief on the organization of prison health", United Nations Office on Drugs and Crime/World Health Organization, available at www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf.

WHO (2014), *Prisons and health*, World Health Organization, available at www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf.

B. International standards and principles for the treatment of people with psychoactive drug use disorders

Council of Europe

Pompidou Group (2017), "Opioid agonist treatment. Guiding principles for legislation and regulations", Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/2017-ppg-15-oat-guidingprinciples-final-eng/16808b6d9e.

United Nations

UNODC (2012), *TREATNET Quality Standards for Drug Dependence Treatment and Care Services*, United Nations Office on Drugs and Crime available at www.unodc.org/docs/treatment/treatnet_quality_standards.pdf.

WHO/UNODC (2020), *International standards for the treatment of drug use disorders*, World Health Organization/United Nations Office on Drugs and Crime, available at www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.

European Union

EMCDDA (2018), *Health and social responses to drug problems. A European guide*, European Monitoring Centre for Drugs and Drug Addiction, available at www.emcdda.europa.eu/system/files/publications/6343/TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf.

EMCDDA (2018), "Preventing overdose deaths", *Perspectives on Drugs*, European Monitoring Centre for Drugs and Drug Addiction, available at www.emcdda.europa.eu/system/files/publications/2748/POD_Preventing%20overdose%20deaths.pdf.

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United Kingdom

NICE (2012), "Drug use disorders in adults", National Institute for Health and Care Excellence, available at www.nice.org.uk/guidance/qs23/resources/drug-use-disorders-in-adults-pdf-2098544097733.

USA

APA (2010), *Practice Guideline for the Treatment of Patients with Substance Use Disorders* (2nd edn), American Psychiatric Association, available at https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf.

C. International standards and principles for people deprived of liberty with psychoactive drug use disorders in prison

Council of Europe

Stöver H. and Teltzrow R. (eds) (2017), *Drug treatment systems in prisons in Eastern and South-East Europe*, Pompidou Group, Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/drug-treatment-systems-in-prisons-in-eastern-and-south-east-europe/168075b999.

United Nations

UNODC (Treatnet), "Drug dependence treatment: interventions for drug users in prison", United Nations Office on Drugs and Crime, available at www.unodc.org/docs/treatment/111_PRISON.pdf.

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In light of the high proportion of people with drug use disorders in the criminal justice systems and their right to the highest attainable standards of treatment, the contemporary international standards for comprehensive treatment have been compiled as part of the Pompidou Group's South-East Europe Co-operation Group on "Developing comprehensive drug treatment systems in prisons" to be applied in the criminal justice system and custodial settings. This background paper is based on a human rights approach and on the current body of evidence-based knowledge of the treatment of people with drug use disorders. It aims at supporting healthcare providers and all other stakeholders responsible for people with drug use disorders in the criminal justice system in their care and treatment in accordance with international standards. The paper includes presentations and recommendations of standards of the relevant legal framework, primary and secondary healthcare services, psychosocial and pharmacological treatment, continuity of care and a literature review of documents on international standards.

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