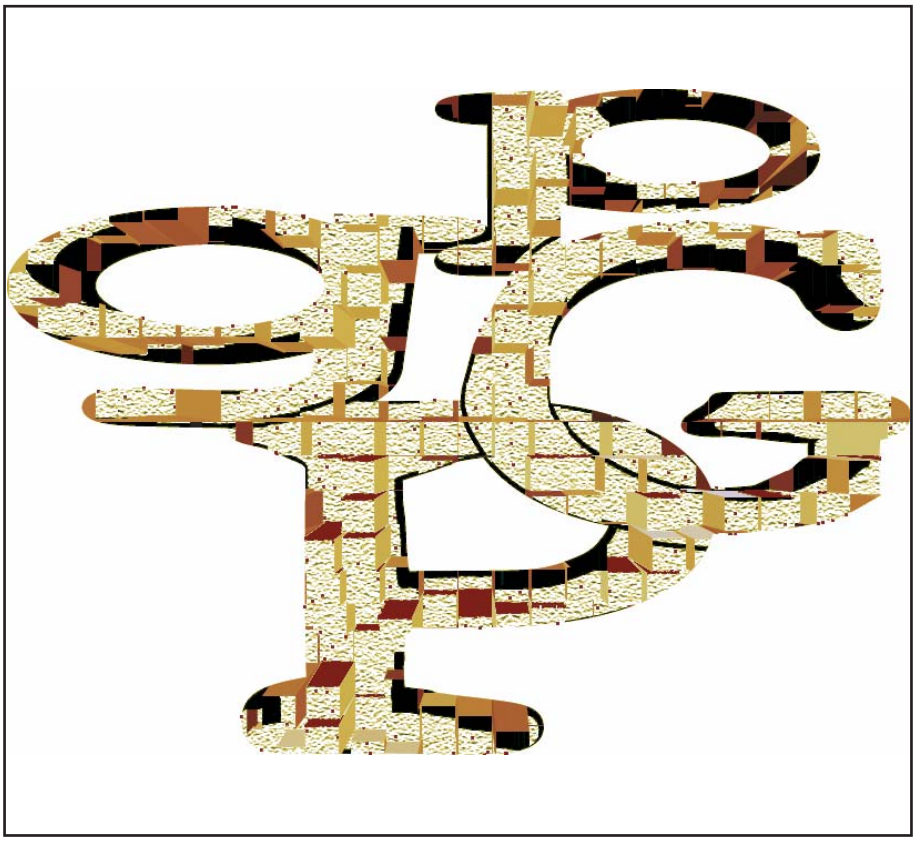
Drugs and addiction



Prisons, Drugs and Society

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PRISONS, DRUGS AND SOCIETY

p r o c e e d i n g s

**Conference co-organised by
the Co-operation Group to Combat Drug Abuse
and Illicit Trafficking in Drugs (Pompidou Group)
and the World Health Organisation,
Health in Prisons Project (HIPP)**

Bern (Switzerland) 20-22 September 2001

Drugs and addiction

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The Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) is an inter-governmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe. It provides a multidisciplinary forum at the wider European level where it is possible for policy-makers, professionals and experts to discuss and exchange information and ideas on the whole range of drug misuse and trafficking problems. Its current work programme includes the promotion of global drug strategies at national, regional and local level; the improvement of data collection systems in Europe; the stimulation of transfer of knowledge and experience between the relevant administrations and professional groups in Europe on issues, policies and programmes for drug demand reduction; the promotion of effective implementation at European level of international drug control treaties and the improvement of cross-border collaboration against trafficking.

The opinions expressed in this publication are those of the authors and do not necessarily reflect those of the Council of Europe/Pompidou Group.

Introduction

The Conference on “Prisons, Drugs and Society”, which took place in Bern from 20 to 22 September 2001, was organised jointly by the Pompidou Group and the WHO Regional Office for Europe (Health in Prisons Project), with the participation and on the invitation of the Swiss authorities. The programme of the Conference is set out in Appendix I.

The main aim of this Conference was to review the current situation concerning drugs in prison and to produce, on behalf of policy-makers and prison and health authorities, a Consensus Statement to guide future developments in this area.

The Conference was attended by 100 participants from 33 countries who represented the prison administration, the prison health and social service and the drug policy or public health areas. Three international governmental organisations and seven international non-governmental organisations were also present. The list of participants figures in Appendix II.

The Conference was divided into 3 sessions:

During the first session, an attempt was made to review the general context of the interactions between prisons, drugs and society.

The second session analysed the size and nature of the drug problem in Western and Eastern European prisons as well as the efficacy of health strategies.

Lastly, in the third session, participants discussed the role of key actors and facilitators such as the judiciary, the media, the prison staff and the prisoner.

The main outcome of the Conference was the adoption of a Consensus Statement on prisons, drugs and society.

This Consensus Statement comprises four main parts. The first relates to principles and the second to policy and practice. This second part is arranged around the different stages an offender or prisoner can pass through within the criminal justice and prison systems. The third part deals with some cross cutting issues.

Checklists for key staff and governors make up the last part of the Statement.

This publication contains a selection of reports presented at the Conference, as well as the full text of the Consensus Statement.

A review of the general context

Drugs and society

François van der Linde

This Conference is being held in a country which often has a reputation for being very conservative, but which in terms of drugs policy tends to go its own way. Although this paper is not intended to be a presentation of Swiss drugs policy, the following comments will inevitably be influenced by our experiences here. The extent to which these experiences can be applicable to other countries depends much less on the properties of the various drugs themselves than on social factors. It is therefore interesting to look at the influences at work in the framing of national drug policies. Put very simply, there are three broad areas:

- Pharmacological and medical considerations;
- Socio-cultural influences;
- Economic and political factors.

Pharmacological and medical considerations

The effects and potentially harmful consequences of psychoactive substances are well known. Quite a number of years ago, Professor Uchtenhagen attempted to draw up a comparative table of the risks inherent in the most widely used substances. Without going into details here, the table showed that it was very difficult to compare the risks inherent in the use of the various substances, but that overall there was no definite link between the risks associated with a drug and its legal status. The reasons why some substances such as cannabis are prohibited and others such as alcohol are allowed are not primarily medical. If drugs policy were dictated solely by pharmacological and medical considerations, then alcohol and tobacco would need to be regulated much more strictly and controlled in a similar way to cannabis products. The fact that this is not the case bothers a lot of people, particularly young people, who fail to understand why the father is allowed to drink his beer but the son is not allowed to smoke his joint. For many people such a situation calls into question the credibility of the State – but here we are already

looking ahead to the social or political part of my statement. From the medical point of view and in the current state of our knowledge, the use of any psychoactive substance entails risks; consequently, there is a clear need for a differentiated approach to regulation in which health risks are taken into account. Blanket tolerance is just as inappropriate as blanket prohibition. Rather, experience has shown that regulations are most effective not when they are introduced across the board but when they relate to specific situations in which the use of psychoactive substances can also cause harm to others (e.g. on the roads, in the workplace, during pregnancy). There is clear medical justification for stricter regulations for the so-called hard drugs, but that does not warrant a blanket prohibition on consumption here either.

Socio-cultural influences

Whereas medical considerations should in reality be the same everywhere, from the socio-cultural viewpoint there are significant differences from country to country. This can already be seen in the terminology used. For example, the German language uses a variety of terms for currently illegal substances, depending on the country or the particular attitude of specific population groups. None of these terms is inherently correct. Rather, they reflect the attitude of the State or individual to the use of these substances, and here a variety of value judgements can be clearly seen. Is the use of illegal psychoactive substances – for whatever reasons – fundamentally a bad thing and is it therefore desirable to try and bring about a drug-free society? Or is the use of drugs from the moral and ethical standpoint in principle neither good nor bad? If so, the main focus should be on preventing not consumption but the detrimental consequences, i.e. damage limitation.

If I may, I would like to digress slightly to talk about the Swiss situation, which may shed some light on this aspect. It is not by chance that in Switzerland at the end of last year some 1038 patients, both male and female, were being treated in one of the 20 centres providing heroin-assisted therapy, that Parliament will soon be debating decriminalising the use, possession and acquisition of small quantities of cannabis and that cannabis products are already being used in practice for medicinal purposes. In essence, there were two factors which brought this situation about. First, a high level of concern at the use of all types of legal and illegal psychoactive substances, but particularly drugs such as heroin and cocaine in the

1990s. Second, Swiss society is extremely pluralistic and liberal, or has become much more so in recent decades.

This *high level of concern* derives, amongst other things, from the fact that the Swiss are among the highest consumers in Europe of all types of psychoactive substances. In particular, the heroin epidemic in the early 1990s coinciding with the then highest number in Europe of people suffering from HIV-related infections and AIDS obliged public health officials and the authorities to take exceptional measures. Open drug scenes were tolerated in the interests of reaching as many people as possible who were at risk of contracting the HIV virus until the criminal activities associated with them left no alternative but to close them down. These open scenes were a necessary mistake (with equal emphasis on both words). As far as HIV prevention was concerned, they were demonstrably effective given the situation at the time. In particular, the population as a whole learnt how to cope better with the drug problem. Even if people did not want these open drug scenes and felt somewhat threatened by them, the existence of the drug problem could no longer be ignored. It was at that time that a willingness emerged to find pragmatic solutions without expecting to solve the drug problem as a whole. However, now is not the time to discuss further why addiction is so high in Switzerland.

Nevertheless, there is perhaps some connection with the second factor I mentioned, namely that Switzerland has become a *pluralist and liberal society*. This was reflected in the 1999 "Cannabis Report" published by the Swiss Federal Commission for Drug Issues. Here is a quotation from the chapter on "Ethical implications of a liberal policy on drugs":

"One of the criteria on which every drugs policy will be judged is how well it reflects society's moral values and civil liberties. The core element of human rights and of a morality founded on the consensus of the community is the protection of individual rights, dignity and freedom of choice. This common aspiration is enshrined in the catalogue of fundamental rights established by every society which is based on the rule of law and democratic principles. How each individual should live his life and the goals he or she should pursue in a liberal society, are matters which only the individual can decide. There is no consensus within society on these questions and no such consensus is sought. In a pluralistic society, thus, there is no guarantee that answers to questions of personal lifestyle by which an

individual or a group may regard itself as bound will also be viewed as binding by all the others."

Consequently, there is support for the notion of freedom of choice and, hence, freedom of consumption among adults provided this causes no harm to anybody else. Obviously, there must be specific measures to protect minors. A clear distinction has to be made between a liberal approach in the sense described and indifference in the sense of a "laissez-faire" approach. The clear message that any use of psychoactive substances carries risks and the factual communication of those risks take on perhaps even greater significance against the background of a fundamentally liberal stance.

The key question is whether one can accept a liberal ethic or whether the State – and especially the majority of its citizens – have other moral viewpoints. The different models of drug policies in Europe today are to a large extent the result of such socio-cultural differences. However, these differences solely concern attitudes to consumption, possession and, possibly, small-scale dealing. In a country governed by the rule of law, there can be no question of tolerating the criminal activities associated with large-scale dealing for profit.

The medical and socio-cultural considerations logically lead to the conclusion that in future the State must cease making its policy exclusively drug-specific but work out a coherent and comprehensive drugs policy, encompassing all psychoactive substances. There should be regulations for all psychoactive substances – as there are already for legal psychoactive substances – classified according to how dangerous they are and their social significance. Clearly, under such circumstances, freely available heroin is not an option. But fresh thought also needs to be given to the widespread problem of under-age youngsters having easy access to alcohol and tobacco.

Economic and political factors

Lastly, there are economic and political considerations. The drugs-policy debate in Switzerland has shown that political parties' reactions to attempts to decriminalise illegal drugs follow the usual left-right divide, whereas the population itself, particularly in liberal circles, has shown a greater willingness to accept pragmatic solutions. On the economic front, little interest in the problem has been shown as long as it does not upset the day-to-day economy. Reactions are quite different whenever attempts are made to incorporate legal

psychoactive substances into a comprehensive drugs policy. One such attempt, limited to supply-side prevention, came up against unexpectedly fierce resistance in Switzerland from both the tobacco and the alcohol industries and had to be dropped, so as not to jeopardise the proposed legislative changes for illegal drugs. The tobacco industry is particularly sensitive, and its steps to hamper effective prevention initiatives were described in detail in a report commissioned by WHO at the beginning of this year[1]. Nonetheless, there is growing public awareness that youth protection measures cannot be limited to illegal drugs.

In framing its national drugs policy, Switzerland has the advantage of being able to take public opinion into account through its system of direct democracy. Controversial draft legislation is sooner or later put to a referendum. On this subject, there were two landmark referenda in 1997 and 1998 in which both a popular initiative for a strict abstinence-oriented drugs policy and a second initiative for far-reaching liberalisation were rejected by over 70% of votes. In contrast, a positive result was achieved by the decision on the previously mentioned heroin-assisted treatment, which is probably the first time anywhere that such a measure has been taken by popular consensus. Amongst other things, it provided for 15 approved treatment places in a prison.

Convergence of drugs policy models

In Europe, the drug problem is still being addressed in a variety of ways. Put somewhat simply, there are three main approaches:

- the *therapeutic model*, which views drug dependence first of all as an illness and which focuses on curing patients. This model takes a primarily symptomatic approach to the drugs problem;

- the *social control model*, which is based on the objective of a drug-free society and places the emphasis on abstinence. In this model, social control and suppression are key factors in the national drugs policy;

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[1] Chung-Yol Lee, Stanton A. Glantz: The Tobacco Industry's Successful Efforts to Control Tobacco Policy Making in Switzerland. Institute of Health Policy Studies, University of California, San Francisco, January 2001.

- the *damage limitation model,* which accepts drug use as a social reality. Drug dependence is often regarded as a passing phase in the life of a person, and damage limitation is intended to help ensure that this phase is passed through without, or with the least possible, harm.

Analyses have shown that although these three models continue to exist, there is a trend towards convergence. The longer and more intense the drug problem in a society, the greater the realisation that a drug-free society even in the longer term is unrealistic. More and more, in a large number of countries, there is a shift away from dogma towards pragmatism. In many places this is by no means easy as pragmatic solutions are often equated with a permissive approach to consumption. But even – or especially – in countries which adopt a damage limitation approach to drugs policy, there is a need for clear signals about the risk of using psychoactive substances, and it is essential that there should be a clear definition of the types of situation in which drug use will be tolerated.

It is difficult to assess whether the differences in drug policies in Europe will remain in the longer term or whether the current trend towards convergence will continue; this depends primarily on socio-political factors. There is no single “right” drugs policy, either in Switzerland or elsewhere. However, the social developments taking place in an increasingly integrated Europe would appear to imply that the process of convergence described above will continue step by step.

The prison, today and tomorrow

Vivien Stern

I would like to start by thanking the Swiss Government for being such excellent hosts, and for showing the way to the rest of the world in developing a rational drugs policy. I would also like to thank Cees Goos and the World Health Organisation for organising this event. Also I am grateful to the Council of Europe. We in Europe are very fortunate that we have such an organisation as the Council to protect the rights of all of us. This is indeed something to treasure and of which we should be proud.

I am speaking to you today not as a representative of any organisation or country, although I come from the United Kingdom, but as someone who has spent many years working with prisoners, prison staff and prisons. I am delighted to say that I have met many of the people at this Conference in the course of that work and made many friends. I am also, of course, very pleased to be involved in a Conference of the Health in Prisons Project.

As all of you in this room know, the prisons of the world are not healthy places; they are not sanitary and can be a breeding ground for disease. They are often places of terrible violence. (In Brazil several prisoners are killed every week, either by other prisoners or by law enforcement officers). Sometimes they are places of torture. They are places of poverty and malnutrition and can be places of corruption.

Penal Reform International produced a small study on the transmission of HIV in prisons in Malawi, Africa. They were told how prisoners with money bribe guards to get them a boy from the juvenile section, who is then rented out for sexual purposes. In Malawi, as in many other countries, guards are very badly paid.

And, as you know better than I, prisons can be places of disease. In Puerto Rico in 1999, for example, 94% of the prisoners were shown to be infected with hepatitis C.

So, for me, it is a very important opportunity to be talking to people responsible for providing medical services to prisoners. You are people whose work in prison can be like a beacon, a shining light in the midst of much inhumanity and misery.

Sadly, however, it is not always so.

I remember well a visit to a prison in Japan which was a pre-trial detention centre. Each prisoner was on his own in a tiny cell for 23 hours a day. We met the prison's medical officer who took us to his office and showed us a collection of objects in a glass case. There were pieces of metal of every shape and size; twisted forks and spoons and pieces of tin that prisoners had swallowed out of desperation, hoping that they would become ill which would allow them out of their cells and into the prison hospital. He showed us the X-rays indicating where these objects had ended up in the prisoners' bodies, and talked of his skill in removing the objects, sewing them up and sending them back to their cells. He was quite proud of his work, so it seemed. He did not suggest that there was a deeper problem and did not comment on what was making these prisoners do such damage to themselves. His job was not to ask questions, his job was to take out the bits of metal and sew the prisoner up.

Fortunately many doctors who work in prisons are not like that. I am thinking of Dr Veronique Vasseur who was the prison doctor in La Santé prison in Paris. French health care is said to be the best in the world – this is not the case in prisons.

Dr Vasseur was shocked by what she found. She describes filthy cells infested with rats. Most of the mattresses were full of lice, and she describes treating dozens of prisoners with a skin disease which they got from eating mouldy bread – a disease seen in wartime but not often otherwise. She describes a prisoner going completely crazy in the segregation block. She is called to the scene and witnesses the guards opening the door and hurling themselves in. She finds a bit of the prisoner in which to put the needle to give him an injection. She never sees his face.

She was shocked, so what did she do about it? She wrote a book. It caused a scandal, and now prison reform is on the agenda in France.

Another example, also of a woman prison doctor, whose prisoners were dying. This was in a special prison for prisoners with TB in Colony 33, Mariinnsk, Siberia. She had no medicines, no equipment and not enough proper food. So she took a bold decision, not popular with her bosses. She contacted Médecins Sans Frontières and asked for help and they sent Hans Kluge. The story of his work at Colony 33 can be read in the book “Sentenced to Die” copies of which are available at this Conference.

It is because of people like that doctor that the TB situation in Russia, in Kazakhstan and in other places is at last getting better rather than worse.

Many more examples can be given of doctors working in prisons who have been shocked by what they have seen and by the work they are required to do, and the action taken to change it. Doctors are enormously respected as a profession and this respect can give them great authority in prisons, to say what needs to be said, to speak out for human rights and public health. They can say that the treatment of many mentally ill in prison falls far short of acceptable standards. This is what the Council of Europe Committee for the Prevention of Torture did when they saw, some years ago, a mentally ill man, cowering naked in the corner of a cell in a Swiss prison.

TB spreads when prisoners are crammed into overcrowded rooms. This is often the case in the pre-trial prisons, the SIZOs, in many countries in Eastern Europe where there may be less than one metre of space per person and with shutters on the windows keeping out the light and air. Doctors can say that these shutters must be removed or made to open.

They can also say, as the Committee for the Prevention of Torture has said, that women prisoners giving birth shall not be chained to beds – ever.

They can say that solitary confinement is bad for mental health. When there are a number of cases of young people in prison committing suicide, as has happened in England, they can say that it is not good enough to go round the cell removing anything that sticks out so that there is nothing from which they can hang themselves. It is not enough to screw the beds to the floor so that they cannot hang themselves from the upturned beds. The question to be asked is: “Why are all these disturbed young people being sent to prison?” We

also need to ask ourselves what is wrong with our treatment of them that they are so suicidal.

Overcrowding is certainly an issue. A health care person telling judges that sending too many people to prison is bad, is worth a hundred human rights people like me telling them that.

This Conference is about drugs in prison and what I have said applies to that particularly. The so-called war on drugs has been a disaster for prisons throughout the world. It fills prisons with people who are addicts, sick people; it opens up many opportunities for corruption; it intensifies the subordination of the addicted prisoners to the prisoners who control the supplies and it increases the violence endemic in prison life. It increases the spread of disease through the sharing of needles.

The battle to stop illegal drugs coming in leads the authorities to take measures that greatly worsen the treatment of prisoners. In some English prisons, prisoners' families visit them in rooms covered by cameras and patrolled by special dogs. Every now and then the prison staff watching the cameras see something suspicious going on and they swoop, breaking up the visit in front of the screaming children.

On this issue doctors have such an important role in raising every time the question: "Is addiction not a health problem rather than a criminal problem?" Switzerland is a good model for this. We should all perhaps be watching with interest the development in Portugal where addicts are being offered treatment rather than arrest and punishment.

For doctors who work in prison to be able to have an effect on the treatment of prisoners, for doctors to represent the public health interest, they need to be independent. They need to be able to function as true professionals working for their patients who are the prisoners.

I am therefore very pleased to be able to say that after many years of resistance the head of the prison health care service of England and Wales now works not in the Ministry of the Interior (there is no Ministry of Justice in England) but in the Ministry of Health.

That is why it is so important to raise the standing and the confidence of prison medical service staff throughout Europe, to enable them to assert the values that are so needed in Europe's prisons today.

Drugs in prisons: the realities

Harald Spirig

The title of this paper raises a number of problems, yet no more so than the theme of the seminar itself.

“Drugs in prisons: the realities” – this seems to suggest that we are at last going to get to know the real situation. Or does it mean that we don’t know, or that we know only part of the story? Or that, although we could find out, there are things we don’t really want to know? Whatever the case, what is generally known about “drugs in prisons” seems quite far removed from the reality of the situation.

However, there is not just one reality, but several. Each may be internally coherent, depending on one’s approach and standpoint. No description of reality can be exhaustive, and so mine too will fail on this count.

The approach which I have chosen is to summarise as dispassionately as possible what we have learned about the reality in prisons. I shall put forward a few abstract premises which I shall then substantiate with concrete examples from everyday experience.

- Premise 1: Drugs in prisons are the rule rather than the exception.

- Premise 2: The right to protection from crime is not recognised.

- Premise 3: The right to health protection is not recognised.

- Premise 4: Controls are ineffective and even detrimental.

- Premise 5: Practitioners are aware of all this but are prevented from taking appropriate action.

Premise 1: Drugs in prisons are the rule rather than the exception

For a long time enquiries into the reality of prison life were a neglected area of general research. The foremost concerns were, on the one hand, the open drugs scene and rehabilitation programmes, and on the other, police action against users and dealers. The few people looking into what came after prosecution and sentencing, namely, the situation in prisons, were for the most part already interested, for one reason or another, in the penal system.

The situation often varies considerably from one country to the next, and even domestically the differences are frequently significant. Yet sufficient data has been assembled to permit a reasonably clear view of things. This is due in no small measure to the work of the many participating international scientific networks.

There have been developments, with a marked change in the composition of prison populations and their consumption habits. In the mid-1980s roughly 10% of prisoners were seriously dependent on opiates, while conservative estimates put the figure at around 20% today.

The overall proportion of drug users among prison inmates has risen continuously. It can be assumed that up to 20% of inmates continue on a regular basis, even while serving their sentences, to inject drugs intravenously, with a preference for heroin. Regularly means several times a week. When irregular or occasional IV users are included, the figure increases to half of the prison population. Add the consumption of cannabis products and the proportion is even higher. Finally, if account is also taken of the problem use of other psychotropic substances such as medicinal drugs and alcohol, there remains only a small minority of sentenced prisoners who are not affected in one way or another. Poly-drug use is widespread.

As always, there is too little funded research, which leads to a fair amount of uncertainty because of the gaps in our knowledge. It is difficult to determine the exact scope of the problem. However, this reality remains: although drug use originally concerned a minority of prison inmates, today it is widespread and commonplace.

Premise 2: The right to protection from crime is not recognised

One reality is that drug possession and dealing are prohibited. Another is that a high level of demand exists and needs to be met. This leads, inevitably, to the well-known further reality of the black market. The strictly controlled environment of all prison establishments makes it difficult to obtain and deal in drugs. Prices are therefore correspondingly high in a "market" whose participants are mostly poor. Drugs are a common prison "currency" and change hands, alongside traditional currencies such as tobacco, in transactions of all kinds. Yet another reality concerns the familiar corollaries of black markets everywhere: increased crime among all prisoners in the form of theft, violence and extortion.

To give just one example: a farmer from the Tyrol was imprisoned for assault in the course of a brawl. Until that point his record had been clean and he had never had any dealings with the so-called criminal milieu. He was relatively quickly granted periods of prison leave. When he failed on one occasion to return, it transpired that he had shot himself. The background to events was that, being above the suspicion of the prison authorities, he had been blackmailed into drug smuggling by fellow inmates using threats of violence against members of his family. While this example is rather extreme, there are many others like it.

Most offences of this sort escape detection. Victims have very little opportunity to defend themselves, and those responsible are seldom punished. The number of unrecorded offences is correspondingly high.

Peripheral crime involves prison officers as well as prisoners. Cases arise again and again of guards who have been drawn into smuggling by the prospect of large profits.

Premise 3: The right to health protection is not recognised

The reality of the black market results in poor quality drugs, and the shortage of proper equipment often means that consumption takes place under extremely unhygienic conditions. Needle-sharing is common, with prisoners speaking, for example, of what they call "petrol pumps" which

are used repeatedly by a number of addicts with no or insufficient disinfection.

The health consequences are a high risk of HIV and/or hepatitis infection. The available data clearly indicates that infection rates – especially for hepatitis B and C – are rising. Among IV users, they have reached 80% or even higher. For the sake of comparison, in the Austrian population as a whole the hepatitis C infection rate is estimated at around 0.5%.

It is in the nature of prisons that they group together large numbers of people against their will, in confined spaces and for protracted periods of time. The risk that infections will be transmitted is therefore high. Those at risk are not only prisoners using drugs but also their fellow inmates, members of the prison staff and all members of the public who come into close contact with infected individuals following their release.

The treatment of health problems will cause severe financial difficulties for prison authorities, if this is not already the case.

Premise 4: Controls are ineffective and consequently detrimental for those concerned and for society as a whole

No prison is truly “airtight”. No checks, however careful, are capable of covering all paths leading in and out. While all efforts made to this end may to some extent reduce supply, they cannot do more than that. At any given time, there are and always will be individuals whose addiction is so severe that, regardless of the risk to their health, they will allow no judge or internal sanction to stand between them and their drug. In such cases dependency is primarily an illness. You can hardly tell a person with flu not to have a temperature, and round-the-clock policing will do nothing to help because what the sick need above all is a doctor. The concurrent issue of liability for punishment remains a matter for the prosecuting authorities to decide.

The costs associated with controls are huge, since they concern not only dependent users but also occasional users and all other inmates. Controls serve to increase tension and force the black market and sub-culture into areas where they are even harder to oversee. They tie up

human and material resources and damage the atmosphere in the establishment for both prisoners and staff.

There are cases where the opposite is true. Hirtenberg prison, which is located to the south of Vienna, houses around 250 medium-term prisoners. Drug-free blocks set up five years ago now account for perhaps three-quarters of capacity. Controls are now limited for the most part to urine tests. Meanwhile, prisoners benefit from numerous privileges such as open areas, periods of unaccompanied release and breaks in detention. Controls have been extensively replaced with the notion of prisoner involvement and responsibility. The level of drug use has fallen sharply. Another very different consequence, although it is at least as important, is that the sickness rate among the prison guards has declined from 14% to 5%. The effect has been a significant increase in staffing levels.

Most forms of preventive and therapeutic support, of which some countries now offer a wide range, are as a general rule combined with the withdrawal or, at least, the shelving of controls. The legitimate question of the effectiveness of therapeutic measures, which is asked more frequently at times when resources are scarce, must also be raised in respect of all control measures. Having more guard dogs and cameras will exacerbate rather than solve the drugs problem.

Premise 5: Practitioners are aware of all this but are prevented from taking appropriate action

The last two or three years appear to have brought a change in the attitude of many prison staff. In contrast to earlier observations and pronouncements, the fact that drugs exist in prisons is now recognised by all concerned. A corollary to this is the increasing admission of helplessness, an admission which is often coupled with resignation. It also frequently goes hand in hand with indignation and anger, reflected either in aggressive and judgmental attitudes towards drug using prisoners or, conversely, in frustration at the impossibility of offering them greater assistance under existing circumstances. Many officers state off the record that they would be prepared to make an immediate broad-based switch to, for example, needle-exchange or other more progressive programmes, but that they lack the backing to do so in the form of legislation or approval from above. Examples demonstrating the

feasibility of such a move are available not only in Switzerland, the country hosting this seminar, but elsewhere too. This new viewpoint is expressed not only by officers in close everyday contact with prisoners, but also by middle and senior management and even by prison governors.

Notwithstanding the great diversity in individual prisons' practical approach to the drugs problem, I feel that this noticeable change is of some significance.

Conclusion

Today's "reality in prisons" would suggest a need for conceptual changes at several levels.

- The determining feature of prison policy to date has been an approach which seeks primarily to individualise the problem, in other words, which sees drug-dependent prisoners as a minority who need to be fought or supported. It is crucial to acknowledge the basic fact that drugs are a part of everyday reality. The earlier situation of "normal" imprisonment, where it was possible to build reasonably good relations and co-operate with so-called "normal" criminals, has been superseded by a population which is remarkable for the comorbidity of a number of characteristics, be they psychological traits, drug use or some other element.

  A view is gaining ground which focuses primarily on prison administration and sees prisons as places housing a group of human beings (staff as well as prisoners) whose health and well-

  being are the responsibility of the prison authority. This offers a major opportunity for a comprehensive prevention programme which will extend to all areas and all people. Meanwhile, it remains important, for example, to offer specific support measures for drug addicts, but only as a secondary, yet integral, component of an overall strategy. Comprehensive prevention of this sort is in the interests of prisoners and of those employed in prisons, but it is also in the interests of the community into which prisoners will be released.

- Controls are necessary to enable prisons to perform their protective role whenever this is necessary and justified. Instead of measures to control the uncontrollable, however, there is a need for new forms which could be described as “regulatory”. These range from preventive and supportive measures governing everyday prison life to a review of existing laws and regulations.

Development of a reader for HIV prevention and management in prisons

Paola Bollini

Introduction

Eastern Europe and the former Soviet Union are experiencing a rapid increase in injecting drug use in the society, with few prevention and harm reduction programmes available to injecting drug users (IDUs). As a consequence, the incidence of human immunodeficiency virus (HIV) infection is rapidly increasing among drug addicts and their partners, with explosive situations documented in specific communities where injecting drug use is concentrated (MAP, 1998). The increase in the community has rapidly been reflected in the prison system. For example, in Ukraine the number of HIV positive prisoners rose from 451 in 1996 to about 18 000 in the year 2000. In the Russian Federation, the number of HIV positive prisoners was 239 in 1996, and about 15 000 by mid-2001.

Prison administrations, and their health departments in particular, were suddenly confronted with a new health hazard, particularly worrisome in the light of the extremely scarce resources allocated to the prison system, of massive overcrowding, and of the concurrent epidemics of sexually transmitted diseases and tuberculosis (Stern, 1999). In several countries, the first and only response was to identify and segregate HIV positive prisoners (Bollini *et al*, 2001). A small group of people, already active in the field of prison health, suggested preparing a book on HIV prevention and treatment in prisons, specifically targeting prison doctors from Eastern Europe and the New Independent States (NIS). A proposal was submitted to and approved by the Open Society Institute, in the framework of the International Harm Reduction Development Program. The preparation of the book began in April 2000. This brief presentation will summarise the development of the project and the main challenges faced by the authors throughout its implementation.

Developing the book

The main objective of the project was to provide prison doctors and administrators from the NIS with the latest information concerning HIV prevention and treatment, according to the 1993 WHO Guidelines on HIV Prevention and Management in Prison (WHO, 1993). Throughout the preparation of the chapters, the authors were confronted with two main challenges. The first was to make available information on the sensitive issue of HIV prevention in prisons which would be of real use to prison doctors from the NIS. The solution was to outline the main problems concerning health and human rights of prisoners within the current reality of the prison system in the NIS. Several examples of the way HIV prevention and harm reduction are organised in prisons in other countries were also provided, to underline the need for prison administrations of the NIS to build a strategy which is appropriate to their reality. The second, but equally important, challenge was to provide guidance on the treatment of HIV/AIDS in a situation where resources are sorely lacking. The solution was to provide extended information on the treatment of common opportunistic diseases, offering different treatment schemes in case first choice drugs were not available to the prison system. In addition, at the request of prison doctors (see below), information on treatment with antiretroviral drugs was provided. Although these drugs are still very expensive, they may soon become available at a lower price, and their use can reduce the human and financial costs of the treatment of AIDS-related conditions.

The steps followed in the development of the project are shown in Figure 1. First of all, the main themes to be addressed in the book were identified. A draft Table of Contents was prepared and discussed by the project partners (Penal Reform International, Médecins sans Frontières and the World Health Organization, Regional Office for Europe). From the outset, it was clear that the book could not consider HIV infection in isolation, but that other diseases and general principles of health in prison also needed to be considered. The material that the authors decided to cover was organised in a Foreword, 10 Chapters and 4 Appendices, as shown in Table 1. The outline was approved by the Department of Penitentiary Administration of the Ministry of Justice of the Russian Federation. A group of experts from both Eastern and Western Europe was contacted and agreed to take part in the project.

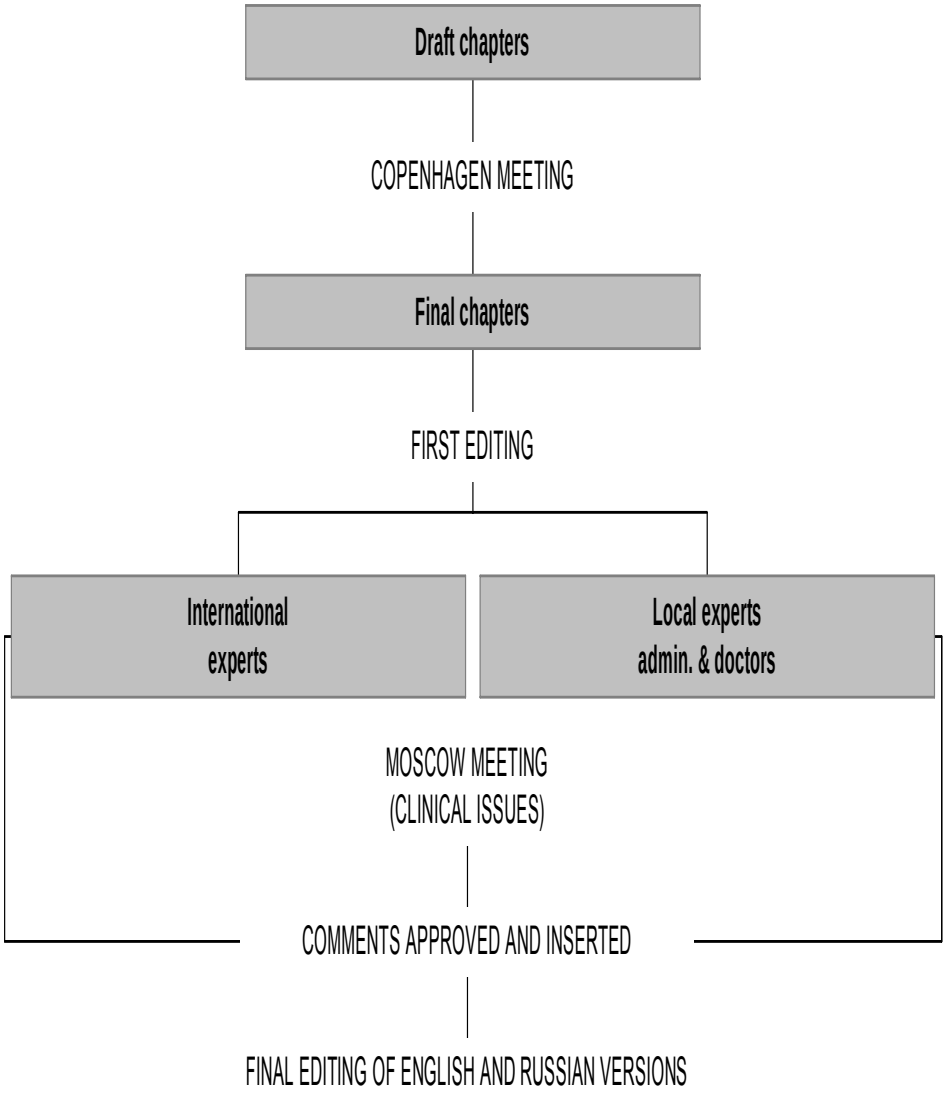
Draft chapters were discussed at the first meeting of the group, held in Copenhagen in October 2000. The most important accomplishment of the meeting was to create a common vision among the authors concerning HIV prevention and harm reduction in the reality of the NIS. The authors were asked to amend their initial drafts according to the decisions made in Copenhagen and to send a revised copy to the editor. A first editing, looking particularly at consistency in the presentation of the material, was conducted in the course of February 2001, and the edited chapters were then returned to the authors. The first complete draft manual was then circulated among the authors. Some authors sent back comments on the various chapters, which were inserted into a specific database to be used at a later date. A printed copy of the book was sent to a group of international reviewers in March 2001. The reviewers were chosen on the basis of their knowledge of the prison system of the Russian Federation or of a specific subject matter. Their comments were also inserted into the above-mentioned database.

At the same time, the text was translated into Russian to be reviewed by the Ministry of Justice and the Ministry of Health of the Russian Federation, and by a group of prison doctors particularly knowledgeable in the field of HIV prevention and management in prisons. Their comments were again inserted into the database, to be used in the final revision. The chapter on the treatment of HIV/AIDS deserves a particular mention. In order to make the chapter more relevant to their needs, it was crucial to understand the current treatment options available in prisons in the Russian Federation. A translated copy of the chapter was made available to prison doctors from Nizhnii Novgorod, Penza, Krasnodar and Omsk, asking them to share it with their colleagues and with the Regional AIDS Centers of their respective oblasts. Dr Richard Bedell, the author, met with representatives from the four oblasts and from the Ministry of Justice to discuss this chapter during a two-day meeting in Moscow. The meeting was extremely helpful in identifying the current needs of prison health authorities in the Russian Federation. At their request, additional information was added on the use of antiretroviral treatment, because the participants were of the opinion that drugs not yet available in the Russian Federation might soon become so in the framework of the international movement to make antiretroviral treatment affordable to all countries.

Overall, the comments received from the Russian and international reviewers were quite positive. Two general comments are worth noting. First, the need to make the material even more relevant to the Russian Federation: to this end, additional data and examples concerning HIV prevention activities sponsored by Médecins sans Frontières and Penal Reform International in some oblasts have been included. The second general comment was that the book is a collection of chapters with different styles. This was unavoidable, as it required too many different areas of expertise than could possibly be covered by a single author, and because certain chapters were required to cover the subject in greater detail than others. In its final version, the book is a manual on different aspects of HIV prevention and management in prisons (Bollini, 2001). The Russian translation will be completed and made available in the NIS at the beginning of 2002.

	Title	Content
Foreword		Presentation of the manual by PRI, MSF and WHO.
Chapter 1	HIV/AIDS in prison	The chapter serves as an introduction to the manual. It addresses health in prison in general a HIV in prison in particular. Examples from Western and Eastern European countries are provid
Chapter 2	Human rights in prison	Human rights of prisoners, according to international legislation, and the duties of the State.
Chapter 3	Risk behaviour in prison	Risk behaviours specific to prison context, using information relevant to the context of the Rus Federation.
Chapter 4	Monitoring HIV infection in prison	Basic principles of monitoring HIV infection in prison.
Chapter 5	HIV prevention in prisons	A review of prevention activities, presenting several examples from different countries.
Chapter 6	Treatment of HIV/AIDS	The chapter presents updated knowledge on treatment of HIV/AIDS, including opportunistic diseases and antiretroviral therapy.
Chapter 7	Tuberculosis and HIV/AIDS	A summary of prevention and treatment of TB in prison, with particular attention to dual infecti with HIV.
Chapter 8	STI prevention and treatment	Current diagnostic and treatment approach to sexually transmitted infections.
Chapter 9	HIV and women prisoners	The chapter addresses the specific situation and needs for prevention and treatment of HIV fo women prisoners.
Chapter 10	Protecting prison staff	The chapter covers in detail the protection of prison staff from HIV and other blood-borne infec
Appendix I	WHO 1993 Guidelines	Text of the 1993 WHO Guidelines reproduced.
Appendix II	Current HIV-related prison legislation	Summary of the current legislative framework in the Russian Federation, including implications mandatory testing, segregation, and prevention activities.
Appendix III	Developing a model for HIV prevention and management in prison	A short chapter on how to develop a comprehensive strategy for HIV prevention and manager in prison.
Appendix IV	List of useful addresses and websites	Compilation of useful addresses and websites concerning HIV/AIDS, in English and Russian.

Figure 1 – HIV reader development process



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The size and nature of the problem

Assistance to drug users in European prisons – Results of an overview study

Heino Stöver[2]

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

Introduction

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

Despite these limitations prison authorities have a duty to ensure that:

- prisoners are treated with respect by all levels of staff;
- prisoners are encouraged to improve themselves;

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[2] see www.archido.de

- prisoners are able to have contact with their families, partners and relatives;

- prisoners should feel safe in prison.

The following key findings of an overview study on "Assistance to Drug Users in European Prisons" are presented, which has been carried out on behalf of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) during 1999/2000.[3]

Drug users in prison

Despite heterogeneous definitions, drug users in prison constitute a major problem in terms of security for the prison system and health risks for the inmates. Although nearly every EU country has developed diversion approaches and puts emphasis on the need for treatment, the number of drug users who end up in prison is high. This reflects, on the one hand, increasing sentencing policies and, on the other, the fact that drug users are often excluded from alternative sanctions (like electronic monitoring, community sanctions) or open prisons. This leads to an increase in the drug using prison population. Characteristics of this group are: extremely socially deprived, several stays in prison, a number of treatment attempts, high relapse experience, severe health damage (including irreversible infectious diseases). Drug users are thought to be the largest homogenous group within the prison population. Generally this group serves relatively short sentences which often makes treatment planning difficult.

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

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[3] see www.emcdda.org

It is difficult to draw a detailed picture of drug use in prison in one country, and even more so for the 15 EU member States. Drug use in prison takes place in extreme secrecy and isolated factors such as seizure statistics, finding of needles/syringes, positive urine test rates only reflect one part of the situation. The patterns of drug use vary considerably between different groups in the prison population. For instance, drug use among female prisoners is significantly different from that of men prisoners, with different levels and types of misuse, different motivations and behavioural consequences.

A questionnaire was sent to Ministries of Justice about drug-related problems in prisons and the following answer was received several times: “First of all precise epidemiological data on drug use and drug-related health problems in prisons do not exist. Information about health matters is not centrally registered, so I am unable to give you any figures about that. It is however evident that a great many inmates have psychiatric problems”.

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

- The use of illegal drugs in prisons seems to be a long-standing phenomenon dating back to the late seventies (for France, see Trabut, 2000, 24). Needle sharing at that time was extremely widespread (for Germany see Stöver, 1994, 41ff).

- Some studies state that the same substances available outside prison are to be found inside with the same regional variations in patterns of use (see Trabut, 2000, 24). Some studies state that these drugs are often of poor quality compared to that available in the community.

- The prevalence of drug consumption varies depending on the institution. The phenomenon is more significant in large institutions and in short-stay prisons, more in women’s prisons than in men’s prisons, more in prisons near a city than in prisons in the countryside (see also Trabut, 2000, 24). De Maere (1999) found indications of less drug use prevalence in remand prisons, because of the lack of organised trafficking networks.

- The most commonly used drug in prison besides nicotine is certainly cannabis, used for relaxation purposes. A Dutch

study revealed that out of those using drugs during detention, 45% used cannabis (Bieleman *et al.*, quoted in van Alem, 1999, 8). Strang *et al.* found that in a sample of 1 000 male prisoners, 62% used cannabis in prison and 18% used injectable drugs in prison. Edgar and O'Donnell found 76% claiming to have used drugs in prison, of whom virtually all had used cannabis at some time. Heroin use does seem to play an important role among prisoners (Machado Rodrigues, 2000, for Portugal; Todts *et al.*, 1997, for Belgium). Results of Mandatory Drug Testing in England and Wales revealed that in 1998, 18,9% of those inmates tested used illegal drugs.

- Several empirical studies indicate that although the number of drug users is relatively high on admission, the use of drugs declines after imprisonment (for Portugal, see Machado Rodrigues, 2000), (for Spain and UK, see Muscat, 2000). This may be due to the reduced supply of drugs or it may also reflect the ability of drug using inmates to stop using drugs while in prison. Only a minority seem to use drugs, using the preferred drug on a daily basis. Some studies indicate that half of former drug users continue their drug use in prison.

- The basic question of whether prison influences the motivation to stop drug use is answered by Muscat (2000, 14) as follows: "... prison on the whole does not motivate individuals to stop drug use ... in the ... countries reporting a reduced drug use within prison, this would appear to be unrelated to the motivation of the drug user to stop per se but rather is a consequence of reduced availability, lack of resources to procure drugs or the fear of detection". Whether these factors finally create the motivation to stop drug use is unclear. These factors outside often lead to an inconvenient social life and are reported to be important to stop the habit, mostly in the fourth decade of life.

- There might also be more reasons for inmates to use drugs while in prison. Trabut (2000, 25) states that some users describe a constant search for drugs to fight boredom and endure prison, to deal with the hardships of prison life or to overcome a crisis (bad news, conviction and sentencing, violence etc.) It seems that imprisonment sometimes provides even more reasons for taking drugs or continuing the habit, or causes relapse after a period of withdrawal.

- Lifetime prevalence of the use of illegal drugs (any) prior to imprisonment is relatively high: i.e. 62,24% for men and 54,55% for women in Portugal (1989 Survey in all central prisons, Machado Rodrigues *et al.*, 1994). A study of 1 009 prisoners in 13 prisons in England and Wales revealed that three quarters had used cannabis at some time during their life, more than a half had used opiates (mainly heroin) and/or stimulant drugs (amphetamines, cocaine and crack), 40% of them had injected the drug(s). Lifetime prevalence of the use of illegal drugs (any) among prisoners in prison is not as high in Portugal, i.e. 48,46% for men and 20,47% for women.

- In some countries alcohol seems to play the major role or is the second most commonly used drug (after cannabis, apart from nicotine, cf. Marshall *et al.*, 1998) among people either admitted to prison or already in prison. Recent figures (from France) show that 33,5% of new admissions declare an excessive use of alcohol (more than five glasses per day or five glasses consecutively at least once in a month (Ministry of Justice, France 2000). In Belgium, Todts *et al.* (1997) found that 28% reported a history of alcohol abuse, for which 16% had already been treated. In some countries, alcohol seems to play the major role among people admitted to prison: according to a Finnish health survey from 1992, about 60% of inmates were diagnosed as alcoholics and 13% were estimated to be drug users (Mäki, 2000). These figures can also be found in England and Wales. Singleton *et al.* (1998) recorded harmful drinking patterns in 63% of male sentenced prisoners and in 39% of female sentenced prisoners, before entering prison. A Danish study published in 1990 (Kramp *et al.*) showed that 50% of the clientele (inmates and offenders under supervision) had abused alcohol when the crime was committed, 25% had been treated for abuse of alcohol before incarceration and 33% were reported to be in need of treatment. Due to the scarcity of the preferred drug changes in patterns of drug use (volume and type of drug) are reported from many countries. The frequency of drug use decreased in relation to that in the community (Edmunds *et al.*, 1999). Those who continued to inject did so at irregular intervals and at a reduced level (Meyenberg *et al.,* 1999, Shewan, 2000, Turnbull, 2000, 101; figures indicate that this is the same in Ireland). Studies show that consumption of drugs while in prison seems to be significantly higher among injecting drug users than among non-injecting users (Trabut, 2000, 24).

Other studies and observations of prison officers indicate that switching to alternative drugs (e.g. from opiates to cannabis) or to any substitute drugs with psychotropic effects – no matter how damaging this would be (illegal drugs and/or medicine) – is widespread. Due to a lack of access to the preferred drug or because of sharp controls (such as mandatory drug testing) some prisoners seem to switch from cannabis to heroin, even on an experimental basis (Edgar *et al.*, see Turnbull, 2000, 99), because cannabis may be detected up to 30 days after consumption as it is deposed within the fatty tissue.

- Drug use in prison may be characterised as follows:

  - high variations in the availability of drugs, that means a constant change of periods of withdrawal and consumption;

  - quality, purity and concentration is even harder to calculate than outside prison;

  - widespread polydrug use to bridge periods of inability to finance drugs.

- Despite the difficult prison circumstances some prisoners use the prison as an opportunity "to take a break, to recover physically" (Trabut, 2000, 26), or to stop using drugs in prison because of the threat of detection via drug testing (especially for those using cannabis). Often this time of abstinence is accompanied by a stabilisation of their general health (weight gain etc.). Furthermore, many drug users in prisons come from the more disadvantaged groups in society, with low educational attainment, unemployment, physical or sexual abuse, relationship breakdown or mental disorder. Many of these prisoners have never had, or have chosen not to take up, access to health care and health promotion services before imprisonment. The medical services therefore offer an

opportunity to improve their health and personal well being (Goos, 1999).

- With respect to stopping injecting, Turnbull (2000, 100) identifies several reasons:

  - personal choice (including an assessment of the risks associated with injecting);

  - practical (including the problem of acquiring drugs, needles and syringes);

  - economic (the cost of drugs);

  - decreased overall drug consumption.

- The percentage of those prisoners continuing to inject in prison is around 16%-60% according to different studies in Europe[4] (overviews: Muscat, 2000, 12; Turnbull, 2000; 101, O'Mahony, 1997; Rotily & Weilandt, 1999; Koulierakis *et al.*, 1999; Christensen, 1999). A survey was carried out at local level in seven European countries in 1997 using a common methodology. It showed the proportions of active injecting drug users who had taken drugs within the 12 months prior to imprisonment. Among prisoners in 21 prisons they ranged from 9% in France to 59% in Sweden, with 16%-46% in Belgium, Germany, Spain, Italy and Portugal.[5]

- Needle sharing and drug sharing is widespread among prisoners who continue injecting (Meyenberg *et al.*, 1999; Rotily & Weilandt, 1999). Although injecting drug users are less likely to inject whilst in prison, those who do so are more likely to share injecting equipment, and with a greater number of people (Turnbull *et al*., 1994). Koulierakis *et al.* (1999) found in Greek penitentiaries that 50% of those who reported injecting in prison shared their equipment with other prisoners. The EMCDDA (2000 Annual Report) reports a high

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4 Results are consistent whatever the methodology (ex or current inmates, face-to-face or self applied, on remand or sentenced prisoners).

5 European Network on HIV/AIDS and Hepatitis Prevention in Prisons.

prevalence of sharing injecting equipment within prison, which may reach 70% of the injectors in some prisons[6]. The Drug Misuse Statistics Scotland (1999, 126f) showed that 5% of all prisoners reported injecting drugs in prison during the past six months and 4% reported sharing injecting equipment whilst in prison. The figure of 4% sharing is equivalent to 82% of injectors. The majority of inmates who are continuing to inject do so with used equipment. This was confirmed by the evaluation study of the first German pilot needle exchange projects. Prisoners reported a frequency of needle sharing in prison nearly seven times higher than outside (before the pilot scheme started). That means many drug using inmates experience a relapse in hygienic injecting behaviour, because they were generally used to easy and anonymous access to sterile injection equipment outside. Some prisoners take even greater risks inside prison than outside. Allwright *et al.* found in their Irish national survey that 58% of injecting drug users in prison said they had shared all injection equipment (i.e. needles, syringes, filters, spoons) while in prison, compared to 37% who reported sharing in the month prior to being incarcerated. This resulted in serious health consequences. Of those who had shared equipment inside prison, 89.1% had tested positive for hepatitis C, compared to 62.2% of those who had not shared injecting equipment in prison. These findings conform to studies throughout the world[7] identifying

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6 Sources:

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7 Covell *et al.*, 1993; Turnbull, Dolan and Stimson, 1990; Carvell & Hart, 1990; Magura *et al.*, 1993; Muller *et al.*, 1995.

injecting and the sharing of injecting equipment within prisons. In reporting on the first documented outbreak of HIV in 1993 within a Scottish prison population, 43% of inmates reported injecting within the prison – and all but one of these individuals had shared injecting equipment within the prison (Taylor *et al.*, 1995). In a review of empirical studies in the UK in respect of needle sharing, 62%-100% of respondents admitted having shared needles at least once while in prison. (Turnbull *et al.*, 1996) found that when considering other injecting equipment, more sharing occurred than was actually reported. Much re-use of equipment was viewed simply as "using old works". The sharing of "cookers" and "filters", and drug sharing by "backloading" and "frontloading" were common. The concept of "sharing" tended to be understood by respondents as relating to the tool of injection (needles and syringes rather than other equipment); the use of tools in the art of injection (rather than for mixing drugs); proximity (multiple use of needles and syringes in the presence of others); temporality (shorter time elapse between consecutive use of needles and syringes previously used by another) and source (hired rather than borrowed or bought). They conclude that syringe sharing is an integral part of drug use and drug injecting in prison. The data reinforces the need for interventions and initiatives to be developed within prisons to deal with the considerable risk posed by continued injecting drug use.

- Figures from a European study and some national and single prison-based surveys indicate that the number of those starting to inject while in prison ranges from 7%[8] to 24%. A recent national survey of Irish prisoners (N=1205) (Allwright *et al.*, 1999) found that 20% (n=104) of those respondents who had a history of injecting drug use (n=506) reported that they had first injected drugs while in prison (see also Gore *et al.*, 1995). Marshall *et al.* (1998, 62) found in their prison survey that 24% of those who used opiates reported their first time use in prison. Of 3,922 prisoners surveyed in 1997/98 1% reported having injected for the first time while in prison (Department of Health 1999, see Turnbull, 2000, 100). Little data is available on the percentage of those prisoners starting to use cannabis products for the first time in prison. According

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[8] European Network on HIV/AIDS and Hepatitis Prevention in Prisons, Annual report to the European Commission, May 1998.

to Marshall *et al.* (1998, 62) 11% indicated that their first experience of using cannabis took place in a prison. De Maere (2000) found in an empirical study in Belgian prisons (self applied questionnaire) that 18.5% started to use cannabis while in prison, 6.5% heroin, 6% benzodiazepines and 4.5% cocaine (for Ireland, see Ingle, 1999).

- According to a French study, some prisoners discover new substances while in prison (medicines, Subutex, see Trabut, 2000, 24) or develop habits of mixing certain drugs they did not mix outside. Although taken from a Bulgarian study (Nesheva & Lazarov, 1999) the use of over-boiled tea and over-pressed coffee seems to be quite common in prisons: "Coffee and tea were available in the shops located in every prison: any prisoner could buy a certain quantity. Relatives visiting prisoners and sending them packages could give them coffee and tea. These two sources were "legal" permitted by the prisons' rules." The study revealed that there was also an illicit market for coffee and tea in the prisons. Those who used over-boiled tea and over-pressed coffee bought the ingredients at inflated prices from other prisoners. This exchange introduces new elements into the general picture of inter-prison relations. A user could, for example, collect tea and coffee from the other prisoners as a payment for protecting them. The usual ways of preparing these two drugs were as follows: 50, 100, or 200 g (or more) of tea was put in boiling water and boiling continued until there was a significant reduction of the liquid. The result was a dark brown, concentrated liquid above the tea leaves. Users usually drank this liquid, although it was suspected that some administered it intravenously. Fresh coffee, again 50, 100, 200 g or more, was pressed several times or boiled as above. It was then drunk, although once more, some may have been injecting it. The above-mentioned quantities usually comprised one dose. There were two main ways of drinking: either all at once, or over 15-20 minutes. Although none of the interviewees reported injecting these substances, there was some anecdotal information that others did. The use of over-boiled tea was more common than the use of over-pressed coffee. The substances were generally used in the late afternoon or evening. There were cases of group use, but users tended to use these products alone. These products are generally

stimulating, as a result of the caffeine extracted from them. Some sorts of tea contain up to 2-3 times more caffeine than the average coffee sample. Taking into account the pharmaco-dynamic aspects of caffeine – theophylline and theobromine – some level of biological dependence is expected to develop.

- Due to a study including data on treated drug users in 23 European Cities (Pompidou Group, 1999, 12) the classic picture of the injecting drug user is vanishing, and smoking heroin ("chasing the dragon") plays a significant role all over Europe. In some countries where injecting is not widespread outside prison (e.g. Netherlands), this route of administration is not widespread in prison either. There have been some indications that users of injectable drugs turn to alternative (and risk reduced) routes of administration namely inhaling, smoking or sniffing (Greece, Spain). However, in other countries where injecting is the dominant route of administration outside prison, alternative ways are not applied in prison, because they seem to be more expensive than injecting, which gets the maximum out of a minimal amount of drugs (Meyenberg *et al.*, 1999).

- There is a high risk of acquiring communicable diseases (especially HIV/AIDS and hepatitis) in prison for those who continue to inject drugs and share equipment. Several studies conducted outside penal institutions reveal a strong correlation between previous detention and the spreading of the above infectious diseases (Kleiber, 1991, 35; Müller *et al.*, 1995). Although injecting drug use in prison seems to be less frequent than in the community, each episode of injecting is far more dangerous than outside due to the lack of sterile injecting equipment, high prevalence of sharing, and already widespread infectious diseases.

- The attitudes to drug use in prison indicate that certain drugs (in particular cannabis and benzodiazepines) are often regarded as serving a useful function, or helping to alleviate the experience of incarceration. This is the result of the qualitative research among inmates and ex-inmates carried out by Marshall *et al.* (1998). "Many inmates seem to regard cannabis as essentially harmless. Alongside these attitudes, inmates recognise a need for treatment among those with serious drug problems and were aware of some of the health

implications of injecting. They also displayed a possibly exaggerated concern about the problems of drug withdrawal. In the same study, prison officer staff shared many of these attitudes, some commenting on the uses of drugs as palliatives and the relative harmlessness of benzodiazepines and cannabis. Others were concerned about the development of a black market in drugs. In general, staff were acutely aware that the problem of drug misuse in prisons reflected a similar problem in the community" (Marshall *et al.*, 1998, 62[9]). Some prison managers confirm the view that the use of some drugs in prison does not vary considerably from use outside. "We do still accept that prisoners who use cannabis are breaking the law and they will be treated accordingly, but we are reflecting the way the world is outside prisons" (The Scotsman, 13/5/98). The Howard League for Penal Reform in the UK recommends in its "Submission to the Home Affairs Select Committee" a decriminalisation of cannabis within prisons[10] and calls for cannabis to be treated in the same way as alcohol, in that it should primarily be a health rather than a punishment issue.

- Many of the drug users in prison had had no previous contact with drug services before imprisonment, despite in some instances the severity of their drug problems (Edmunds *et al.*, 1999; Shewan & Davies, 2000).

- After release, many drug injectors continue with their habit. Turnbull, Dolan & Stimson (1991, 48; see also Edmunds *et al.*, 1999) found in their study that 63% of those who injected before prison, injected again in the first three months after release. "Prison therefore cannot be seen as providing a short or longer term solution to individuals' problems with drugs". There is an enormous lack of preventive measures (including training on "safer use" and preparation of a possible relapse after release) offered in prison. Often there is no concept of risk counselling for the first days after release. If there is some expectation of lifetime benefit, then great effort needs to be

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[9] See also the study of Edgar & O'Donnell (1998) who confirmed that 82% of inmates and 44% of staff were in favour of tolerating cannabis use in prisons and did not see any negative effects on discipline and order.

[10] See www.penlex.org.uk/pages/hldrug99.html

devoted to the post-release period. However, it is unrealistic to expect community agencies to take up that challenge unless they have contacted the inmate during the period of imprisonment. Public health associations should be encouraged to start working with prison authorities in devising standards for health care provision.

Table 1 Proportion of drug users among prisoners

Country	Proportion of drug users among prison population	Date of data	Remarks
Austria	10-20%[1, 14]	2000	10% drug-related convictions; 14% in remand, 17.5% in penal institutions (estim. by prison doctors; 20% estim. by Ministry of Justice, 10/2000)
Belgium	32%-42[1]	1/12/93	Todts *et al.* (1997) found a prevalence of 42% (n=1627)
Denmark	19%[15]-36%[6, 8, 14]	1999	Nationwide survey: 25% of drug users are i.v. drug users; 49% of women's population are drug users; average age 30.6 years; 91% Danish, 4% other European countries, 5% countries outside Europe
Finland	15,2%[9]-31%[15]	1/5/1999	31% results of a survey by National Public Health Institute in 4 prisons, people reported having used drugs
France	32%	1997	Increase of drug users in prison from 10,6% in 1987 to 32% in 1997 (Trabut C, Ministry of Justice, 2000)
Germany	20-30%[11,14,18]	31/3/1999	In some women's prisons, up to 70%. Up to 50% of women's population are considered to be drug users
Greece	26[6]-33%	1995	31% injecting drug users in one prison (n=1183); 33,6% reported injecting drug use at sometime in their lives in 10 randomly selected correctional institutions (n=861)
Ireland	30-52%[17]	1998	60-70% of women's population (Dooley, 1998, 6); "About half of the total prison population is addicted to drugs" (Dr Joe Barry, medical adviser to the National Drugs Strategy Team in Ireland (In: Irish Times, 2000)
Italy	25%[14]-29% (15,097)[2]	31/12/99	
Luxembourg	36%	1/6/1999	

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

* Notes regarding table 1:

1 According to Muscat, 2000

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

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

4 Ministério da Justiça/DGSP/DSS – non-scientific estimation

5 Catalonia sovereign is not included in this field

6 Ministry of Justice (3 July 2000)/documentation

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

8 Reventlow contribution to penlex database (Drugs, Prisons, and Treatment)

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

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

11 Federal Ministry of Justice/Ministry of Health 1995 – non-scientific estimation

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

13 The number of female inmates is between 1.8% (Greece), 4% (NL), 5% (Germany), 5.7% (Sweden) 9% Spain (except Catalonia)

14 European Network on HIV/AIDS and Hepatitis Prevention in Prisons

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

16 Koulierakis *et al.*, 1999

17 Allwright *et al.*, 1999

18 According to a study carried out by prison doctors, 30% of 3 600 male inmates at admission (73% of all female prisoners) in Baden-Württemberg were considered to be drug users in terms of need for counselling and/or therapy (Dolde, 1995)

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

Definitions

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

Table 2: Definition of "drug user" in prison in some EU countries

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

Documentation and scientific research data

Cross sectional views of drug use and health problems mainly at admission are widespread whilst longitudinal perspectives of the development of drug use patterns and drug users' careers in prisons – as well as analysis of health data – are very poor. For a comprehensive understanding of the dynamic, meaning and impact of drug use and risk taking in prison, qualitative studies are also necessary. Van Alem *et al.* (1999) argue that the reason little aggregated data is available is the highly decentralised way in which detention centres and prisons collect and aggregate their own data. There are only a few exceptions at a European level (e.g. Sweden).

The lack of aggregated data makes it difficult to monitor major changes, to describe developments and to compare intervention outcomes. For example, medical checks at the end of the sentence are not carried out regularly due to practical problems, so often there is no overview of the health process of prisoners. Van Alem *et al.* (1999, 14) suggest connecting the criminal justice system and their treatment and inmate health data with the broader information systems which exist in every European country either on a regional or on a national level. In every country, monitoring systems exist which allow at least trends to be identified and treatment needs and outcomes to be documented. They propose the extension of the national databases within the framework of the existing National Drug Monitor (NDM) as well as the European context where, since 1997, a core item has been set to monitor treatment demand (EMCDDA, 1998).

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

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

seem to be necessary. This ensures moreover regular contact with treatment demands and standards.

It is essential that standards of care for prisoners reflect the care provided in the community. The prison health services should, therefore, be encouraged to operate in close co-operation with health care providers in the wider community. Some critics go even further and demand a change in prison health care to better tackle drug use related problems by shifting responsibility from the Ministry of Justice to the Ministry of Health.

It seems to be of great benefit when, as in some countries, concerted action takes place (steering groups or strategy units) with the task of observing and monitoring the developments and possibilities to improve health care for prisoners and especially for drug using inmates.

The principle of equivalence

The principle of equivalence means that health care measures (medical and psychosocial) successfully proven and applied outside prison should also be applied inside prison. With regard to support for drug using inmates, this has turned out to be wishful thinking in many ways. In most countries basic prerequisites are not given (i.e. no continuity of care, no adequate prevention means). Nevertheless, the principle of equivalence is the guiding criteria with which prison drug services have to be measured in the context of the national drug service structure and the drug policies pursued in all EU member States. In particular, differentiation of drug services (including drug-free treatment, methadone maintenance and harm reduction) outside is not reflected sufficiently inside prison. “Prison Health” has to be integrated in the broader frame of “Public Health”.

Organisation of assistance to drug users

If imprisonment itself cannot be avoided, then treatment and preventive steps have to be taken from the first day of imprisonment. This includes comprehensive medical care as well as access to health and social workers both from inside the prison and from the community in order to define the individual psychosocial perspectives. This dual intervention of inside and outside drug services seems to be a successful strategy in tackling the health problems of drug users in prison and afterwards. This is more and more applied and awareness has been raised in recent years. The increase in substitution

treatments outside has led especially to the necessity for inside reactions to this form of treatment.

Medical care

Poor health education and lack of information about the various treatment and prevention facilities in prison (i.e. hepatitis B vaccination, substitution treatment, treatment for hepatitis C patients) currently reduce the potential impact of a stay in prison in terms of access to health care services. Prison medical care could play a much bigger role in stabilising drug users. Voluntary screening (HIV and hepatitis) of inmates is a chance to assess possible infection risks. Although specific counselling in order to start a dialogue with the inmate can be made, screening for infectiological parameters is often perceived by inmates as a control measure.

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

- making sure that inmates in pain have equal access to drugs routinely given for pain relief to patients outside;

- allowing inmates equal access to investigational drugs and non-conventional (complementary and alternative) therapies;

- ensuring that inmates have access to information on treatment options and the same right to refuse treatment as exists in the community;

- assessing health care services in each prison in consultation with outside experts to ensure that the expertise necessary for the care, support and treatment of inmates with HIV/AIDS is available, accessible and efficient;

In the longer term, correctional health care needs to evolve from a reactive sick call system to a proactive system emphasising early detection, health promotion and prevention (cf. Canadian HIV/AIDS Legal Network, 1999).

Drug-free treatment

Services addressed at drug users are basically abstinence oriented. There is much debate about the usefulness of the abstinence approach in terms of a realistic and achievable aim for all drug users described above. Moreover, there is little research (including for the period after release) about the effectiveness of this approach and the possible adverse effects.

Drug-free treatment forms the dominant approach towards drug users in prison. There are different models of drug-free wing/zone, either in the regular penitentiary and in special establishments. The concept of drug-free units (DFUs) which have been established in several European prisons (e.g. Austria, Portugal, Scotland, The Netherlands) seem to be very well accepted both by medical and prison staff and by the administration. Available data suggests that DFUs provide adequate protection from drugs and that they are relatively successful in realising continuity of care.

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

Substitution treatment

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

Drug using prisoners who were receiving treatment in the community prior to imprisonment are often unable to continue their treatment in custody – even in countries with an extended prescription policy outside. Substitute prescribing is often designed as the provision of a symptomatic treatment or a short-term methadone detoxification in the admission phase. Imprisonment, therefore, is very likely to result in the discontinuation of substitution treatment. Abstinence orientation still dominates medical care. Substitution is often seen as

prolongation of the addiction, while imprisonment is supposed to be useful for staying or becoming drug-free. The criteria for the prescription of substitutes are often perceived as transparent and arbitrary. National guidelines are necessary (such as “health care standards” in England and Scotland), but guidelines are not enough on their own, they need local adaptation and implementation. Methadone maintenance is a medically indicated form of treatment that should be available to opiate-dependent people, regardless of whether they are outside or inside prison. In addition, opiate-dependent prisoners should have other treatment options, including methadone detoxification programmes, with reduction-based prescribing, which should be routinely offered to all opiate-dependent prisoners on admission.

Transfer of harm reduction measures into prisons

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

Based on epidemiological and sociological studies on the spread of infectious diseases and dynamics of (injecting) drug use patterns, there is overwhelming evidence for the introduction of harm reduction into prisons. Present prison drug services are too focused on abstinence-oriented measures. A dual strategy of cure (abstinence) and care (harm reduction) is needed. At present, harm reduction measures are poorly developed in prisons throughout Europe. Needle exchange schemes have been introduced in only 19 prisons in Germany, Spain (and Switzerland). Bleach is also a measure only applied in a few countries and very little is known on the use of disinfectants. Even the provision of condoms does not occur in all prisons and, again, everyday access has to be properly checked. Bleach needs to be made accessible easily and discreetly to inmates in all prisons.

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

Knowledge

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

The setting-oriented "Health in Prison" approach

One attempt by public health practitioners to address the challenges of prisons has been within the broader healthy settings movement that has given rise to better-known initiatives such as "Healthy Cities". A "total institution" (Goffman) like prison has to be viewed as a system with people working and living in it. The concept of "Healthy Prisons" therefore focuses on the achievement of health promotion in prison – both for inmates and working staff. This also includes advocating for prisons to be safer environments, both for prison inmates and their communities. Ideally, a "Healthy Prison" should serve the general community by targeting health-improving interventions to a high-risk sub-group (i.e. drug users) of the

community. It should minimise the health deficit and maximise the health gain. Health promotion recognises the social and environmental impacts on health – that their environment determines the health behaviour of populations. Changes in the environment will be necessary to effect health change. Changes in the prison environment will require changes in public policy which will only occur with community support and political commitment.

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

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

Stabilisation of drug addict's physical and social condition

Promotion of health care should be designed to improve living conditions in detention in general because many inmates are without hope and desperate and do not believe that they can permanently improve their situation. This may be one reason for the increased readiness of inmates to take greater risks and to dismiss the implications.

Areas to be investigated are:

- housing (cell, block, office, place of work);
- suitability of food;
- hygiene and cleanliness;
- sanitation;
- autonomy (competence, residence);
- architectural and environmental issues (building, heating, sanitation, light, ventilation etc.);
- spare time, offers for weekend activities, activities offered after 16h00;

- physical exercise, sports;
- visiting and leave regulations;
- availability of therapeutic treatments;
- medical treatment in general.

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

Differentiation inside prisons

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

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

Networking between drug service providers inside and outside prisons and adjustment to the standards applied outside prisons

The needs of the health and justice systems have to be balanced. This suggests that different professional cultures also have to be balanced: social workers and psychologists versus prison officers and administrative employees. This is one of the basic prerequisites for a change in health care for prisoners. The help provided to drug users inside prisons should be balanced with the support services available outside prisons. The special status of support services inside the walls can only be overcome if all the services available to drug users

outside prison are also made available to those inside. A bridge from prison to the community has to be provided. In particular, outside experts should also offer counselling and care inside prison. This can only be achieved if all parties involved are willing to co-operate.

A policy of demarcation is not only pursued by prison managers but also by service providers outside prisons who disregard inmate drug use, mostly because their experience of the control and security regime of prisons has been negative. Hence it is difficult to balance support services inside prisons with those outside. In the presence of mistrust and a reluctance to pass on information, co-operative links from which both parties could benefit and which are urgently needed cannot be established. However, it must be considered that co-operation between outside experts and trained staff in prisons requires compatible working strategies. Despite the different conditions inside and outside prisons concepts that can be implemented in both areas must be developed.

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

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

The increasing number of problems among this group (imprisoned, drug-addicted women) stems from their social situation prior to imprisonment. Impoverishment apparent through increased homelessness and, frequently, a lack of financial security is common. The granting of increased home leave from prison and the suspension of detention (safety aspects are not a real obstacle to

this) could improve the chances of former inmates to find a job or occupation.

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

Opening up prisons to outside groups and service providers

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

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

The objectives of service provision mentioned at the beginning, strengthening the inmate's self-esteem and autonomy, would be reduced to absurdity if possibilities for acquiring and testing (their) physical skills were not accessible to prisoners outside the walls. It seems that NGOs are important in pushing development and introducing change in prison and in the sphere of the different perspectives arising from health and justice affairs.

Analysis of current and future innovative treatment programmes is needed

In some countries, little evaluation is carried out on the effectiveness of the outcome of treatment and intervention measures. Although the "drug problem in prisons" is commonly perceived to be very high and a lot of efforts are undertaken to reduce the associated health risks, there is little evaluation of these efforts. Evaluation does not always have to be carried out by large scale studies. It seems to be necessary to set up specific project groups with the aim of carrying out surveys of drug use, and the current state of affairs of

interventions, and to submit proposals for new treatment initiatives and co-operation with outside agencies.[11]

Research is needed

More research is needed to better understand how some drug users manage to stay drug-free and why others do not. Some of the key topics are:

- epidemiology of health risks in the prison setting (cross sectional and longitudinal);
- identifying key figures for monitoring system;
- better understanding of drug use patterns (drugs, frequency, quantities, routes of administration);
- evaluation of the long-term effects of interventions and derivation of “Good Practice”;
- effects of peer education and peer support;
- in-prison treatment and intervention monitoring: what works and why;
- identifying obstacles to the transfer of harm reduction measures into the prison setting;
- cost effectiveness and cost benefit of in-prison and aftercare programmes.

Bibliography

Please look for the references under:
http://www.emcdda.org/multimedia/project_reports/responses/assistance_prisons_information%20sources.pdf

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

The size and nature of the problem in Eastern European countries (New Independent States)

Alexander Gunchenko

Eastern Europe's penitentiary systems suffer from important problems that differentiate them from prison systems in Western Europe. I have been able to familiarise myself over the past three years with several prison systems in former Soviet countries (Russia, Georgia, Uzbekistan, Kazakhstan, Belarus) thanks to assistance from senior prison administration officials. I am very grateful to the medical services in these administrations for helping me learn about their work.

In spite of relatively uniform initial conditions in Eastern European prison systems, national traditions in the New Independent States have undergone change over the past decade, but those changes have not substantially exacerbated disparities between them.

On the whole, the conditions and position of prison medicine in these countries are similar, and most differences are insignificant. Possible exceptions are the start date of the HIV epidemic and its rate of development, and the level of financing for medical needs. With minor allowances, this makes it possible to assess detention conditions and levels of medical care using the sole example of Ukraine.

What do I see as the main problems facing prison systems?

- the HIV infection epidemic;
- the high incidence of tuberculosis;
- the spread of drug-resistant tuberculosis;
- an increase in the number of tuberculosis patients with an underlying HIV condition;
- funding for the prison system's medical needs, like State funding for the prison system itself, is still governed by the previous regime's approach;

- detention conditions;

- personnel problems;

- doctors' working conditions and the contrast with those of doctors working in the State health system;

- many of these countries' systems are being reformed, obliging them to operate under a double burden: keeping the system "afloat" (routine work) and introducing statutory and legislative reforms (preparing new statutory texts, re-organising structures, bringing detention conditions into line with minimum European standards, resolving staffing problems etc). Unfortunately, reform is taking place in a context of limited funding.

Ensuring respect for the principle of equivalency of medical care is fundamental today: the standard of medical care available to prisoners must correspond to the standard of medical care provided to the population as a whole.

Medical care for the prison population has been improved considerably by the statutory texts of the Ukrainian State Department for Sentence Enforcement. Unfortunately, it is not always possible to guarantee the prescribed level of medical care in all establishments. Providing objective information and eliminating the huge disparities between establishments are currently the main tasks facing the prison system.

The statutory and legislative basis for organisation of medical and sanitary provision in establishments of the penal enforcement system:

- "Principles governing Ukraine's legislation on health provision";

- Ukrainian Law "On ensuring the population's health and epidemiological well-being";

- the statutory and legislative texts on medical and health provision for persons detained in penal enforcement establishments.

The statutory and legislative basis governing the organisation of medical and health provision to persons in custody must be based on the principle of equivalency.

The standard of medical care provided to the prison population must correspond to the standard of medical care available to the country's civilian population.

The HIV epidemic in Ukraine began in 1996 and assumed threatening proportions.

We have already discussed the Ukrainian prison system's adoption of basic principles for preventing HIV infection, and the results of programmes implemented in 1997-1999.

The key principles for dealing with HIV infection in prisons have been implemented in the Ukrainian penitentiary system since 1997, namely:

1. extensive information and educational work among persons detained pending investigation and convicts, and among prison staff;

2. access to condoms and disinfectants and instruction on their use;

3. creating conditions for voluntary HIV testing;

4. introducing pre- and post-testing counselling in prison establishments;

5. refusal to isolate persons who are HIV-positive;

6. guaranteeing confidentiality of medical information.

This approach to HIV infection in prisons has since fully justified our expectations and is the most acceptable approach in prison establishments.

Senior medical personnel in certain countries have raised legitimate objections: "you are refusing to introduce compulsory testing, you are not dealing with the problems, you do not have a real picture of how the epidemic is developing". However, we have three main counter-arguments to these observations:

- we carry out epidemiological monitoring;

- there is extensive information and educational work;

- and, perhaps most importantly, we deal with every person on the assumption that he or she is HIV-positive.

Eastern European countries are dealing with the problem of HIV infection and HIV-positive persons in different ways. In practice, there continues to be compulsory HIV testing and isolation of those who are HIV-positive in most establishments (Kazakhstan, Uzbekistan, certain Russian regions). For example, more than 300 individuals were in isolation in Uzbekistan in April of this year, without confirmation of their final diagnosis (there is a shortage of testing systems). In the first two months of 2001, 148 out of 244 blood serum samples reacted positively in the IFA test.

In prisons in Belarus, Kazakhstan and Uzbekistan, HIV-positive prisoners are kept in strict isolation (local units). In most prisons, there is compulsory testing for everyone entering the penitentiary system. At the same time, in practically all countries, activities to raise awareness about the HIV virus, its transmission and prevention methods give grounds for hope.

In practically all Eastern European countries, tuberculosis is currently the biggest threat to the prison population. More than any other pathology (perhaps even than the HIV virus) tuberculosis is obliging (in a positive sense) the penitentiary phthisical services to co-operate closely with civilian medicine.

Co-operation between prison medicine and the civilian health system is now extremely important. It is essential to work constructively at all levels – Ministries, regional directorates and local divisions.

Unfortunately, many misunderstandings still persist. For example: does tuberculosis come from outside or does it originate in prisons? Does HIV infection come from outside, or from prisons?

Comparison of people suffering from tuberculosis (and persons who are HIV-positive) in pre-trial detention centres and prisons for convicts, and their inter-relation, can demonstrate that infectious pathologies, including the HIV virus and tuberculosis, enter the penitentiary system from civilian society, and only then return to the outside. Accordingly, the number of infected people returning to

civilian society – the “tuberculosis factor” – depends to a large extent on the anti-TB measures adopted in prisons; these in turn depend not least on detention conditions, the availability of medicines to combat tuberculosis and anti-epidemic activities – i.e. on the degree of investment by the penitentiary system. Unfortunately, the current detention and nutrition conditions in most prisons in Eastern Europe are not conducive to improved prisoner health.

In our opinion, it is incorrect to compare the rates of TB infection within the prison system and those in civilian society.

Why?

- there is a compulsory X-ray examination in all prisons within 3-10 days of admission (Ukraine, Russia, Belarus, Uzbekistan, Kazakhstan);

- there is a compulsory annual X-ray examination in establishments for convicted prisoners (in some countries, twice a year);

- the calculation is based on a strictly defined number of individuals in a closed environment.

In our opinion, it would be appropriate to compare TB rates in each country with figures for previous years, and to compare prison systems in the various countries.

Anti-TB measures – the prison system’s strategy:

1. timely prophylactic checkups, active identification of suspected and confirmed TB cases;

2. rapid isolation of those suffering from TB, timely transfer to hospitals treating TB and uninterrupted treatment;

3. strictly supervised administration of anti-TB medicines;

4. testing the phlegm of patients with clinical and X-ray symptoms of TB;

5. immuno-prophylactics and chemo-prophylactics;

6. on-going and final disinfecting measures;

7. constant dietary supervision, with particular focus on the amount of protein in the diet;

8. in regions with high tuberculosis rates – quarterly analysis of the progress of anti-TB measures;

9. continuous co-operation with regional civilian health agencies and institutions set up to combat TB;

10. health-educational work on TB prevention.

Attitude to DOTS?

A favourable response can be given as regards the prison systems of eastern Europe. Once adapted to a country's circumstances, the DOTS strategy is fully applicable. Since January 2001, the Ukrainian prison system has to all intents and purposes adopted the DOTS strategy. I believe we will have the first results by the end of this year; preliminary data suggest that treatment is more effective and that there has been a fall in the fatality rate.

Preconditions for implementing the DOTS strategy in penitentiary establishments

1. a favourable attitude to the DOTS strategy on the part of the department responsible for defining State policy on tuberculosis;

2. targeted financing of anti-TB measures: in particular, the creation of a six-month minimum stock of products for treating TB;

3. sufficient quantities of expendables (chemical reagents, micro-biological resources, X-ray film) and medical equipment (microscopes, X-ray and laboratory equipment);

4. effective supervision of doctors' compliance with the treatment protocol;

5. training for medical staff: seminars, training courses;
6. monitoring of implementation of the DOTS strategy;

7. development and dissemination of printed information on the introduction of the DOTS strategy.

A few words on co-operation between non-governmental organisations (NGOs) and prison establishments, and between NGOs and prison administration structures. Unfortunately, there are currently no clearly defined rules on co-operation between the penal enforcement system and NGOs. One sometimes has the impression that certain NGOs have been set up for their own sake.

We believe it is essential to structure these organisations' expenditure clearly, so that the overwhelming majority of resources is directed towards work in the penitentiary systems. With rare exceptions, the NGOs currently operating exist to provide financial support for their own staff, and waste resources on bright monographs, splendid conferences, presentations, business trips etc.

Activity must be targeted and focused on co-operation to prevent infectious diseases, including tuberculosis, HIV/AIDS and sexually-transmitted diseases, and to inform prisoners about their rights to medical care and their responsibilities.

Aspects of prison medicine in which NGO resources could be deployed effectively

1. epidemiological monitoring;

2. creating an information area (computer network) for establishments and the middle and upper levels of prison medicine administration. Statistical monitoring of infection rates, including tuberculosis and AIDS;

3. conducting information and training seminars on prevention of HIV/AIDS/STDs and tuberculosis. Initial and further training of doctors responsible for conducting pre- and post-test counselling in penal enforcement establishments;

4. publishing eye-catching and understandable information (brochures, leaflets, booklets) on how to prevent HIV/AIDS/STDs and tuberculosis, and material for detainees on their rights and on procedures for receiving medical care in prison establishments;
5. joint projects to supply disinfectants and condoms in prisons.

In summary, it should be noted that the problems facing prison medicine are identical in practically all countries, whether they are developing countries or the countries of Western Europe:

- staffing problems;

- funding principles inherited from previous systems;

- the prison doctor's unique position: responsibility for the patients' health (medical duty) and representing the interests of the prison administration. These roles are not always compatible;

- infectious diseases, tuberculosis, the HIV virus and drug abuse.

The efficacy of health strategies

Drug abuse treatment in the prison milieu: A review of evidence

Ambros Uchtenhagen

Various approaches can be taken regarding the provision of treatment for convicted drug dependent persons. First, there are alternatives to imprisonment, either parole or diversion to external treatment services (in-patient or out-patient). Treatment programmes within prisons are increasingly being provided, usually on a voluntary basis, but experiments with compulsory treatment programmes are also taking place. This paper deals mainly with treatment programmes in the prison milieu or as part of the prison system.

Problems of drug use in prisons

The main problems with drugs in prison include morbidity and mortality risks for users, and risks for first use while in prison. It is very difficult to have a "drug-free" prison, and there has always been a risk of "drug trade" through corruption of staff. The risks have become greater with high rates of drug users among inmates (in Europe, this rate varies from between 10 and 50%, EMCDDA, 2001).

Morbidity risks arise from high rates of needle sharing among drug using inmates. Reported rates were 50-60% (EMCDDA, 2000) 43-75% (Dolan, 1997) and 50% (Koulierakis *et al.*, 1999). It would appear that needle sharing is seven times more likely to occur in prison than outside (Stoever *et al.*, 1996) This has lead to higher HIV and HCV seropositivity rates in IDUs who have been in prison (Kleiber & Pant, 1996).

Objectives of treatment within prisons are:

- to reduce drug consumption in prisons;
- to reduce the incidence of new drug users;
- to improve the health of drug users;

- to reduce the impact of drug use on staff, such as corruption;

- to facilitate follow-up treatment and aftercare.

The need for treatment

The need for treatment for prisoners on remand should receive consideration. 30% of remand prisoners have substance related problems. These prisoners also have more psychiatric conditions, mood disorders, unemployment and qualification deficits than other prisoners on remand (Brooke *et al*., 2000).

The need for new inmates is considerable. 50% of new inmates need treatment (Lo & Stephens, 2000). Drug dependent inmates have more social maladjustment, are less preoccupied with their drug use and less motivated for change than offenders in regular treatment services (Brochu *et al.*, 1999).

Evaluation of treatment

Evaluation research on therapeutic approaches for substance abuse problems in the prison milieu has increased over the last decade. It is justified to complement earlier reviews (Leukefeld & Tims, 1988, 1992).

Research in this field is still confronted with a range of difficulties. Institutional barriers may prevent independent external evaluation, the meaning, orientation and conditions of treatment are hardly comparable, and selectivity of access often remains unclear. Control groups especially from voluntary treatment are mostly not equivalent. The diversity of design and instruments used in evaluation studies also has to be considered. Methodological standards used in treatment evaluation are frequently not met. The following review therefore has its limitations and can only provide an overview.

Treatment modalities within prisons

The range of treatment modalities consists mainly of:

- detoxification;

- drug-free treatment units (Therapeutic Community type);

- substitution treatment for opiate dependence:

- continuation of previous maintenance treatment;
- start of new maintenance treatment;
- aftercare.

Detoxification

The approaches available include:

- agonist substitution;
- opiate antagonists;
- other pharmacotherapies such as Clonidine;
- auricular acupuncture;
- physiotherapy etc.

These are provided to varying extents in different countries. The availability of methadone assisted detoxification is documented for European prisons in Austria, Belgium, Denmark, England and Wales, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Scotland and Spain (EMCDDA, 2001) and also in Switzerland (Karger, 1996). Auricular acupuncture is available in England and Wales, Finland and Germany (EMCDDA, 2001).

It is noted however that in many prisons detoxification takes place without medication, or that inmates may not ask for treatment in order not to be stigmatised as a drug user (Stoever, 2002).

Drug-free treatment

This treatment is being provided in prisons predominantly in special facilities, separate from other inmates, with a high level of control, aiming at abstinence and using urine testing in order to ensure drug-free status. Access is mostly voluntary under certain conditions, as an option.

Programmes are implemented either as drug-free wings (mainly based on a 12-step concept) or as therapeutic communities (using, as far as possible, the same principles as apply to TCs in the community). Modifications of TCs tried out in prisons include

improved diagnostic assessment and the introduction of manualised counselling methods. The activation of self-help is important, and the role of ex-addicts although important is reduced.

Drug-free wings have been created particularly in Austria, Finland, Germany, the Netherlands and Sweden (EMCDDA, 2001, Stoever, 2002). The availability of ITC (In-prisons Therapeutic Community) varies globally. By 1988, it was available in 30 States of the USA (Frohling, 1989). In Europe, there are various models in Austria, Belgium, Denmark, England, France, Finland, Italy, the Netherlands, Poland, Spain, Sweden and Switzerland (EMCDDA, 2001, Karger, 1996). In some countries, drug-free areas have increased three- to four-fold since the mid-nineties, e.g. in Austria, England and Scotland (EMCDDA, 2001). According to a survey, 80% of EU member States have drug-free treatment programmes, although with great differences in the number of treatment places available (Turnbull & Sweeney, 2000).

The elements of in-prison therapeutic community programmes include:

- duration of at least 3 months (up to a non-determined period);
- group therapy;
- individual counselling;
- motivational enhancement and incentives;
- work-release programme;
- residential aftercare and outpatient aftercare.

Although the implementation of ITC is not identical everywhere, the main principles are shared (Wexler, 1995).

Guidelines and standards for ITC have been made available (De Leon, 2001).

Several evaluation studies were conducted as to the outcome of ITC. Overall evaluation confirmed the effectiveness of this approach (Early, 1998, Simpson *et al.*, 1999).

The Delaware prison study (Inciardi *et al.*, 1997) showed, at 18 month follow-up, low recidivism rates in prisoners receiving ITC plus work-release programmes. At 3-year follow-up, there was a significant decline in the programme's effects, although there were better results if aftercare was provided. The study supports the need for a multi-stage therapeutic community model.

A California prison study (Wexler *et al.*, 1999) results at 3-year follow-up showed that the best outcome was for those who had completed both ITC and aftercare programmes. The recidivism rate for those was 27% compared to 75% in the non-completers.

The Texas prison study (Knight *et al.*, 1999a, 1999b, Hiller *et al.*, 1999) results at 3-year follow-up included a re-imprisonment rate of 25% in those who completed ITC and aftercare programmes, 64% in aftercare drop-outs and 42% in untreated comparison groups. There were better results regarding recidivism rates with ITC especially when followed by residential aftercare, in comparison with transitional community-based TC. The benefits are most apparent for offenders with more serious crime and drug-related problems.

A similar study was made in Ohio (Siegal *et al.*, 1999).

A cost-effectiveness study of ITC (Griffith *et al.*, 1999) showed improved cost-effectiveness in comparison to untreated parolees only if the entire programme (ITC and aftercare) was completed. The highest economic impact was evident among high-risk cases.

The Texas prison studies (Newbern *et al.*, 1999) also evaluated the process of ITC and found that increased psychosocial skills were obtained with motivational enhancement methods (such as node-mapping) in comparison to standard counselling. Increased social skills were relevant for the outcome. The importance of motivational enhancement was confirmed by a later review (De Leon *et al.*, 2000).

A study comparing treatment subjects from 20 different prisons in USA (including high, medium and low levels of security) with control subjects showed that those who entered and completed in-prison residential treatment were less likely to experience the critical post-release outcomes of new arrests and substance use during the first six months following release (Pelissier *et al.*, 2001).

In contrast to ITC, the regimes in drug-free wings have rarely been evaluated. One example from Hamburg, Germany, documents less

recidivism with completers of the programme in comparison to drop-outs, and shorter periods until relapse if no follow-up treatment after release from prison was arranged. Interestingly, inmates who applied for the programme, but were not accepted, did as well as those who were on the programme (Heinemann *et al.*, 2002).

Recommendations from ITC evaluation studies

- Motivational enhancement methods increase participation in the programmes as well as compliance and chances for completing the programme;

- a continuum in the treatment approach (that is, ITC, work-release plus aftercare) was a requisite for good outcomes;

- it would also appear that prisoners with a high risk of recidivism should be particularly encouraged to enter such a programme.

Substitution treatment

The principles of prison based substitution treatment are the same as for treatment provided outside prisons. The choice of substitution medication follows the preferences shown outside prisons and is mainly oral methadone.

The availability of maintenance treatment in prisons is documented in 10 European countries: Austria, Denmark, England and Wales, France, Germany, Ireland (short term prisoners only), Luxembourg, the Netherlands, Portugal, Scotland (short term prisoners only) and Spain (EMCDDA, 2000, EMCDDA, 2001), as well as in Switzerland (Karger, 1996). However, most programmes cater for less than 10% of inmates.

The main elements of the treatment programmes are:

- initial assessment;

- supervised intake;

- urine controls;

- counselling.

In some instances, there are deficiencies of programming, such as inconsistent rules and practices. Too much may be left to the discretion of staff and the prison authorities. Limited confidentiality is another possible deficiency.

Other limitations to effective substitution treatment in prisons are:

- methadone prescribing is largely restricted to detoxification;
- predominant drug-free or "maintenance to abstinence" ideology;
- lack of staff and ancillary care resources;
- no continuity of care between prison and community-based services.

Nevertheless, evaluation of maintenance treatment in prisons gives good results:

- there is high acceptability amongst injecting drug users, with a lower frequency of drug use and less involvement in the prison drug trade (Bertram, 1991, Dolan *et al.*, 1998a, 1998b);
- there is also less risk-taking behaviour (Dolan, 1996) and there are less new HCV infections;
- follow-up treatment is more likely than with untreated inmates or those receiving detoxification only (Magura *et al.*, 1993);
- there is reduced delinquency in recently released prisoners (Dolan *et al.*, 1996) although there is less evidence for sustained effects.

Recommendations from evaluation studies of substitution therapy

Methadone maintenance reduces the level of drug-related problems in prisons and should be made available to opioid dependents as an option. The high rate of relapse after release from prison indicates that transfer to a community-based maintenance programme is essential.

Aftercare

Part of the prison treatment programme is aftercare services, such as Phase 3 in US programmes and “antennes toxicomanie” in French prisons.

These programmes include referral to community-based services. The provision of community supervision after imprisonment can be part of the parole service. Outcome studies on parole with intensive supervision found a limited impact of supervision (Hanlon, 1998), but better results were found if supervision was combined with good participation in a rehabilitation programme (BJA, 1992).

Main obstacles for prison-based treatment programmes

The main barriers to an implementation of treatment programmes in the prison milieu are:

- priority has to be given to safety issues;
- negative staff and management attitudes, such as:
    - illegal drug use must be discouraged through sanctions, not by other forms of prevention;
    - illegal drug use must not be facilitated through harm reduction measures nor rewarded by special therapeutic regimes;
- deficits in staff training;
- deficits in high level political support.

Compulsory treatment and the role of coercion

Drug-free treatment and agonist maintenance treatment are mostly optional and not enforced without the inmate’s consent. They are provided as a regime one may apply for and that is usually granted under special conditions only. The ensuing selectivity may have an impact on outcome, as there is at least some motivation for entering treatment, if not for change.

In contrast, a few countries also have compulsory treatment programmes where no consent of inmates is required. Such

programmes are known in Sweden, Germany and the Netherlands. In Norway and Finland these have practically disappeared during the last decades (Palm & Stenius, 2002).

In Sweden, the local Board of Social Welfare decides on an application to the administrative county court for compulsory treatment. However, immediate decisions by the Social Welfare Board alone become more and more the rule. Treatment is provided in 15 institutions for a maximum of six months, usually not in a prison-like setting. The programmes have diverse orientations, e.g. towards a 12-step concept or using transaction analysis (Palm & Stenius, 2002). A deficit of structured therapeutic interventions aimed at drug and alcohol problems is in the process of being dealt with (Gerdner, 1998).

Outcome studies showed that a substantial majority of clients did not improve, and that no great differences could be found between those who were committed and those who were reported for commitment but who were not. Where those committed had less favourable outcomes, this was explained by their more severe substance abuse and problematic social situation (Gerdner, 1998). The unsatisfactory outcome may be due to deficient aftercare and also deficient co-operation with the families of the committed persons (Segraeus, 1994).

In Germany, compulsory treatment can be provided in special institutions, e.g. the Bezirksklinik Parsberg in Bavaria. The duration of enforced treatment is variable, it can be extended to a maximum of four years. A one year follow-up study using several outcome measures documented a relapse rate of 78.3% (if the probands are unavailable for follow-up interviews they are considered relapses). About half of the probands did not show any indicators of change (Stosberg *et al*., 1988).

The street junkie project in the Netherlands was implemented for previously sentenced recidivists who failed in regular treatment approaches. It provides a compulsory in-jail treatment programme for a period of six months. Commitment is made by the court. Another project for compulsory treatment (SOV) will be evaluated in the framework of an EU-funded research project on Compulsory and Quasi-compulsory Treatment of drug-dependent Offenders in Europe (QCT). Outcome results are not yet available.

It is well known that whenever a person enters treatment for substance abuse problems, some form of pressure contributes to such a decision, coming from the court, the social welfare agency, the employer, relatives or from one's own perception of health or social problems. More recent research has attempted to clarify the various forms of coercion into treatment, applying the concept of "coercion continuum" (Weisner, 1990) and the distinction between formal and informal social control tactics (Room, 1989). Measuring coercion has become an issue, focusing on objective circumstances or on subjective perceptions, in order to determine the role of coercion in compulsory treatment. Interestingly, subjective perception and objective circumstances do not coincide and have independent effects on treatment retention (Maxwell, 2000).

It seems that compulsory treatment has better results in terms of retention and referral to community based follow-up treatment, but not in terms of substance use and criminal behaviour (Wild *et al*., 2002). A study that included measurements of treatment motivation found differential effects of compulsory treatment on retention versus involvement in the therapeutic process, indicating a positive effect on retention and a negative one on preparedness for change (Knight, 2001).

The diverse outcome results may stem from problems with finding equivalent control groups and ask for a reconsideration of study designs and methodology (Wild *et al*., 2002).

Development of prison-based treatment programmes

Treatment offers for inmates with drug abuse problems has increased over the last two decades in the USA (Chaiken, 1986, Peters & May, 1992) and more recently in Europe (Steven, 1996). A study of the 15 EU member States concludes that all of them provide some form of treatment activity in their treatment systems (Turnbull & Webster, 1998).

However, there appear to be large gaps in the adequate provision of treatment, care and prevention in prison systems. Mental health problems in comorbid inmates require special attention (WHO, 1998). Also, specific needs of minority groups such as female inmates or migrants are frequently not met (EMCDDA, 2001). A varying proportion, and often a minority only, of drug abusing inmates receive appropriate treatment. Some of the obstacles mentioned above may be responsible for this. Staff education on the care of addicted

inmates is often insufficient, as shown e.g. in an Australian national survey (Kraus *et al*., 2001).

Main conclusions

- Treatment for substance dependence in prisons is feasible.

- Treatment for substance dependence in prisons reduces drug-related problems during incarceration.

- Sustained improvements (reduction of drug use, reduction of crime, social integration) occur if treatment is available as an option and depend on the availability and quality of aftercare.

- Comprehensive programmes with continuity of care and motivational enhancement are to be recommended.

- Adequate staff training and political support are required.

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The role of key actors and facilitators

A new non-punitive order: judicial care of addicts

P.C. Vegter

Introduction

Of all offences committed in the Netherlands, a disproportionately large number can be ascribed to one and the same group. I refer to offences against property either with or without violence by a hard core of very active drug addicts. These offences include breaking and entering, shoplifting, robbery and theft from cars. The police have estimated that about 6 000 persons in our country are involved. These persons create a nuisance, especially in big cities. Recently, a new non-punitive order was introduced in Dutch criminal law with this group in mind. This order can be imposed by the court and is referred to as "Judicial Care of Addicts". For a clear understanding of the matter, I first need to make some comments on the Dutch system of sanctioning adults, before going on to the non-punitive order. Therefore, I restrict myself to convicted males over 18 years. For the moment this order may only be imposed on this group.

If a suspect is found guilty, the criminal court can impose a penal sanction. The Dutch legal system has two kinds of sanction. The traditional punishment is one intending to cause grief – a prison sentence or a fine – and is imposed by way of reprisal. As well as punishments, the Dutch criminal law also includes non-punitive orders. These orders are the product of the so-called Nieuwe of Moderne Richting [*New or Modern School*] which dates back to the beginning of the 20th century. The intended purpose of the order is to ensure that the offence will not be committed again. A hospitalisation order for psychopaths has existed in the Netherlands since 1928. This order concerns persons with a mental disorder or with limited development of their mental faculties. In practice, the order amounts to compulsory hospitalisation for treatment. The term of the order is indefinite, however it needs to be extended periodically by the court, which must then determine whether the detainee is still a potential danger. In the scope of the treatment the detainee is urged to accept a medical treatment scheme. The treatment consists of several therapies and aims at reducing the danger the detainee represents to society, so that eventually the order can be terminated. Hospitalisation is compulsory, medical treatment, however, is not.

Addicts who consistently commit offences against property are a nuisance and it could even be said that they are a danger to society. The question arose as to whether this reason was sufficient to impose the hospitalisation order. As far as I know, this has never happened over the past thirty years because hospitalisation has been reserved for offenders who cannot be held accountable and who commit serious offences, usually of a very violent or sexual nature e.g. assault inflicting grievous bodily harm, rape and manslaughter.

A more recent problem is that of drug-addicted offenders, who are penalised by a short-term sentence and, after serving a few months in prison (as addicts still), continue breaking into cars – altogether a vicious circle. These are systematic offenders and for this group a new non-punitive order was introduced entitled "judicial care of addicts".

Purport of the non-punitive order

The non-punitive order "judicial care of addicts" includes an intensive nursing and counselling programme for addicts[12] who commit punishable offences more or less systematically. The programme starts with committal to a closed treatment centre for about six months. Subsequently, the person is moved to a semi-open setting. During the next six to nine months and with the centre as a base, the person develops more activities in the outside world. In the last phase (nine to twelve months) the person is no longer detained. Living outside the centre, he will follow a programme which is under the responsibility of the municipality.

It was not without a struggle that this non-punitive order[13] was introduced, on 1 April 2001. Not only did scientists raise strong

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[12] The concept of addict is explained in section 38m sub-section 3 of the Criminal Code as a person concerning whom a physical or psychological dependence on one or more substances stated on List I attached to the Opium Act becomes apparent from facts and circumstances.

[13] Act dated 21 December 2000, Stb. 2001, 28. For coming into effect see Stb. 2001, 158. The Act contains amendments of the Criminal Code (sections 38m-38u), Code of Criminal Procedure (section 509y-509gg) and the Penitentiaire beginselenwet [*Act on Penitentiary Principles*]. For the amendment of the Penitentiaire maatregel [*Penitentiary Order*] see Order dated 27 March 2001, Stb. 2001, 159.

objections, the Council of State, official advisory body of the government on legislative matters, was very harsh in its judgement[14]. As yet, nothing can be said regarding the results of the order. In the summer of 2001 some orders were imposed by the court. The plan is to create 350 places for the enforcement of the order[15]. (There was a delay in the introduction of the order because the psychiatric participation needed by the court for advice had not been organised. The forensic psychiatric services had not prepared themselves for their advisory task concerning the potential fitness of suspects).

Conditions for imposing the order

- The act committed by the suspect must concern an indictable offence for which pre-trial detention is possible. (As a rule, it concerns indictable offences carrying a maximum penalty of four years and more).

- The matter of recidivism. (In the five years preceding the act he committed, the suspect was sentenced at least three times to a term of imprisonment or order for an indictable offence).

- There is a serious risk that the suspect will commit an indictable offence again.

- The suspect is addicted to hard drugs and the act committed and the potential recidivism are connected with that addiction. (A difficult decision for which a report by a behavioural expert is indispensable).

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[14] See for example P.A.M. Mevis, Vrijheidsbeneming ter bestrijding van overlast: inderdaad uniek drugsbeleid, [*Deprivation of liberty to suppress inconvenience: unique drugs policy indeed*] Sancties 1996, pp 208-220. Also C. Kelk, De perspectieven van de SOV [*Perspectives of the SOV*], Sancties 1999, pp 208 et seq. and T. Kooijmans, Strafrechtelijk opvang verslaafden [*Judicial care of addicts*] DD 2000, pp 593-609.

[15] The treatment centre for addicts in Utrecht is expected to be operating by September 2001. An article in Het Parool with the heading “De criminele junk wordt opgepakt, zodra justitie is uitvergaderd” [*The criminal junky will be arrested the moment the judicial authorities stop being in conference*] led to questions by Apostoulou (PvdA) in Parliament. The Minister of Justice answered on 31 May 2001. The Minister is of the opinion that the co-operation between the various partners is working excellently.

- The safety of persons or property requires imposition of the order.

I have already said that the introduction of the order was not without a struggle. Why is this order looked upon rather critically in the Netherlands at present? There are other ways than this to treat an addicted suspect. Under certain conditions, pre-trial detention can be suspended, the case can be stayed and a suspended sentence with a special condition can be pronounced. So the value of this order is open to discussion.

The character of the non-punitive order

Reducing nuisance

The new order has a somewhat different aim from existing orders in the Netherlands. There are orders that aim at enhancing security; confiscation is a means of protecting society against dangerous objects and detention under a hospitalisation order is a method of protecting society against dangerous persons. How can the "judicial care of addicts" be classified?

The non-punitive order was introduced for use as a last resort. All other courses must first be tried, after which a suspended order for hospitalisation in a treatment centre for addicts is obvious. The law allows the court the possibility to suspend the imposed order under certain conditions. These conditions may be, for example, that the person seeks medical treatment as an out-patient for his addiction. If that fails, the order can still be enforced. This is justified in view of the far-reaching character of the order. For offences which carry no more than a few months' imprisonment, a two-year non-punitive order may be imposed. This poses the question of the proportionality of the order.

The purpose of the non-punitive order is two-fold. This order focuses especially on reducing nuisance resulting from the offences committed by the drug addicts. The intended result of the order is also to solve, or at any rate control, problems of individual addicted offenders, having in mind their return to society and halting recidivism. Are these two purposes compatible? Primarily, reducing nuisance is the main point. The order cannot be expected to end if detoxification is not progressing because the addict refuses to co-operate in the treatment of his addiction. For this reason, the core of the order is to fight nuisance. Can a sanction which is not in proportion to the seriousness of the offence, as far as deprivation of liberty goes, be justified solely on the grounds of prevention. Now that the core of the order is the prevention of nuisance, the character of the order fits well with the order (and with confiscation). The introduction of the order is fitting in the present-day trend to use criminal law to eradicate social problems as much as possible. It is debatable whether nuisance is sufficient justification to deviate from the principle of proportionality.

The compulsory element

Among lawyers there appears to be a misunderstanding about the compulsory element of the non-punitive order. Within the scope of the enforcement of the order, forced treatment of the addiction is not possible. Any treatment without informed consent is out of the question. In the case of a hospitalisation order for psychopaths, compulsory treatment is the centre point and treatment usually takes place on the basis of a treatment programme drawn up in consultation with the detainee. The compulsory element of the new non-punitive order of judicial care is the hospitalisation. So in this respect, it is no different from a prison sentence. For long-term prison sentences, a care and treatment programme could also be offered. The prohibition of treatment in prison was abandoned not very long ago.

At present, the difference between a prison sentence and the non-punitive order is that in the latter case, the detainee is motivated from the outset by the care and treatment programme. If he refuses to participate, that choice will have to be respected. The detainee may then be forced to stay in the treatment centre for the full two years and may never get beyond the first phase. In this case, the objective of the new order, namely to solve the addiction and any related problems, cannot be achieved. The order's legitimisation is therefore under pressure.

(In the scope of the enforcement of judicial care, however, compulsory treatment is possible in extremely urgent situations. Judicial care does not differ from a prison sentence in this case. Section 32 of the Penitentiaire beginselenwet [*Act on Penitentiary Principles*] authorises the warden to oblige a detainee to undergo a particular medical treatment. A requirement is that the doctor believes this treatment necessary to avoid serious risks to the health and safety of the detainee or to others.)

It is not uncommon for addicts to be prescribed methadone by their doctors. For that reason methadone is an accepted medication. In quite a number of cases methadone appears to be used alongside narcotic drugs. It is difficult for penitentiaries to adhere to a strict methadone policy. In practice, the doctor in each institution holds on dearly to his autonomy. A consistent view on the prescription of

methadone is still not formulated and propagated[16]. Can detainees who are hospitalised in a detoxification centre be obliged to give up methadone? This causes problems in the case of detainees who are prescribed methadone by a doctor outside prison. In the administration of justice, the question of whether detoxification from methadone without the detainee's consent constituted compulsory treatment was answered positively[17]. This means that it is not unlikely for a detainee in a treatment centre to successfully exact the provision of methadone. In such a case, the addiction of the individual will not be solved. At best, the addiction and its related problems will be controlled.

The role of the court[18]

The non-punitive order can only be imposed at the Public Prosecutor's request. This is unique in our criminal legislation and involves a restriction of the court's freedom to apply a sentence. It is reasonable to wish to control the capacity of the treatment centres for addicts, since there are only a limited number of places available for the enforcement of this order. There will simply be no order if there is no place available. That principle could also be used in case of prison sentences[19], but in practice, this is not taken into serious consideration. The restriction of the freedom to apply a sentence is at odds with the aim of the judicial authorities to arrive at a consistent application of punishment. At present, it is conceivable that two very similar addicts are tried and that an order is demanded for only one of

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16 A draft circular letter concerning methadone provision to detainees will be ready by the middle of 2001.

17 See Pres. Court of The Hague 14 August 1997, Sancties 1997, no. 58 m.nt. C. Kelk and Pres. Court of Amsterdam 13 February 1997, Tijdschrift voor gezondheidsrecht [*Magazine for health law*] 1997/46 m.nt. A. Hendriks. The medische beroepscommissie [*Medical Appeal Committee*] for the application of criminal law and care and protection of juveniles follows this same policy in the current administration of justice.

18 See P.M. Schuijt and G.R.C. Veurink, Strafrechtelijke opvang verslaafden en de veranderende taak van de strafrechter [*Judicial care of addicts and the changing task of the criminal court*], Trema 2001, pp 201-205. Also Sancties 2001, pp 65-68.

19 See J.P.S. Fiselier, Het cellentekort [*the lack of cells*], lecture Groningen.

them. The court cannot impose the order ex officio on the suspect for whom it was requested and on the one for whom it was not. The question is whether improper arguments will play a role when it is decided whether or not to request the order. Will the Public Prosecutor's request become part of a consultation with the Mayor and the Chief of Police? This would not really improve the clear demarcation between the roles of the administration and the judiciary. The Mayor could insist on the arrest of X and want judicial care demanded for him, then hint at the fact that the municipality would pay a part of the last phase of the enforcement of the non-punitive order. It could be concluded that the court's decision would lose importance.

One characteristic of a hospitalisation order for psychopaths is that the exact duration is not fixed beforehand. The same could hold good in principle for treatment in the scope of the judicial care of addicts. For one addict one year may suffice, whereas another will need at least two. The maximum term of the order is laid down by law. The order cannot be imposed for more than two years, so less than two years is also possible.

When the duration of the order is not fixed beforehand and it can last no more than two years, there is an understandable need for judicial monitoring. For that reason, the law permits the addict to ask the court that imposed the order for its termination. This is a useful safeguard of legal rights in the following situations: 1. In the opinion of the convicted person the treatment is completed, so the order can be terminated, however those who treat him totally disagree; 2. The person convicted refuses treatment and it is not likely that this view will change within a two year period. The court's decision on the request to terminate the order, especially in the latter case, is of great importance. Should the court be inclined to terminate the order if treatment lacks perspective, this then affects the crux of the order. The court is then considering the possibility to give treatment as being the central purpose of the order rather than the prevention of nuisance. This kind of administration of justice will spread among detainees like wildfire, and these detainees will find their way to court. If the court dismisses a request, it is possible to appeal to the Court of Appeal in Arnhem. A concentrated possibility of appeal offers a guarantee for legal certainty.

Concluding remarks

It will be clear that many questions have been raised that still need to be answered. The court will play an important role in answering them. Will the order end if the addict does not co-operate? Obviously, necessary experience with the order must be gained first. The question is whether the order will be imposed regularly. Not all 350 places can be expected to be occupied within a year after the introduction. This is partly due to the somewhat hasty introduction of the order. When the new act was implemented, the centres and necessary facilities were not all operational. It will be clear to you that I am critical of the new non-punitive order. The reason for this is connected to Dutch culture and practice. It goes without saying that special facilities for addicted criminals are necessary. The result of the introduction of the order is the extension of facilities for addicted criminals. I do not think that a non-punitive order like judicial care for addicted criminals can be introduced in other countries without problems.

Prisons, Drugs and Society:
A Consensus Statement on Principles, Policy and Practice

Prisons, Drugs and Society: A Consensus Statement on Principles, Policy and Practice

Abstract

It is insufficiently recognised that much more can be done within our prison systems to reduce the harm from drugs and to treat successfully a large number of those prisoners who are addicted to drugs. The promotion of health in prisons can make a major contribution to national strategies for tackling the problems of drugs (including alcohol) in society.

Current national strategies to deal with the ill effects of illicit drugs are based upon laws aimed at the reduction of supply, demand, use and harm resulting from drugs. A rising proportion of those imprisoned are there because of breaking these laws relating to drugs. Experience in the WHO Regional Office for Europe's Health in Prisons Project has shown that any national strategy for reducing the harm from illicit drugs must include how to tackle the drugs issues in prisons. Many of those sent to prison already addicted and require treatment and assistance to reduce the harm from their drug use. Prison is a unique opportunity to address these health issues while also addressing the causes of offending behaviour.

This Consensus Statement is based on the accumulated experience and advice of member country representatives of the WHO Health in Prisons Project and the Pompidou Group of the Council of Europe, together with advice from selected experts from many parts of Europe. It was finalised after discussions held by delegates at the WHO/Council of Europe Conference on Prisons, Drugs and Society held in Berne, Switzerland in September 2001, hosted by the Federal Government of Switzerland.

It has been produced for consideration by those in government and non-governmental organisations who influence the development of health-related policies in prisons. It offers the prospect of significant health gain for some of the most disadvantaged and socially excluded groups in Europe. It is important that each country considers the recommendations from a position relating to its own legal, economic and cultural circumstances. As effective implementation is the goal,

this Statement should be brought to the attention of all relevant staff and, where appropriate, also to prisoners themselves, as sustainable progress will only be made if desired policies are understood and accepted by the key people involved.

Underlying the Statement are the guiding principles of the WHO (Regional Office for Europe) Health in Prisons Project. Imprisonment must be seen as taking away the freedom of inmates as the sole legally decided punishment. Imprisonment must not remove the dignity and remaining autonomy of prisoners, or their self-respect and sense of responsibility for their future health and welfare. Many of them are already from those groups in society that are most deprived, lacking in education, with low self-esteem, suffering the effects of poverty, lack of employment and often with poor mental health.

In recommending high priority for the circulation, consideration and implementation of this Statement, the sponsors of this document wish to emphasise that all recommendations are based on current best practice. In several countries in Europe, many of the recommendations are already implemented and are known to work. Europe should strive to be the first WHO Region to have comprehensively and successfully tackled the problems of drugs in prisons, and in so doing contributed considerably to harm reduction from illicit drugs throughout society.

To facilitate implementation, appendices have been added providing guidelines and checklists for key staff and governors/managers of prisons. It is important to share as much information as possible with prisoners and this is covered within the checklists.

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What action should follow on from the published statement?

- Member countries and partner organizations are asked to draw this statement to the attention of key policy-makers and practitioners.

- All who create or implement policy in this area are invited to check current practice against this guidance, and to consider taking action, including resource implications where appropriate.

- Consideration should be given to following up and reporting on action taken, so that the benefits of learning from each other's experience can continue.

Constraints, limitations and opportunities

It is recognised that prisons and drugs have to be considered in the particular social, economic, cultural, legal and political context of each member State. What may be appropriate to a well-resourced prison in an economically wealthy country may be inappropriate or no more than an aspiration in a prison operating on a tight budget in a country facing major economic challenges. Similarly, the total size of the prison population and number of prisons in each system will make tackling drugs in prison a much bigger challenge in some countries than it is in others. Differences of values and culture, including attitudes to drugs, as well as locally devolved powers, can result in very different approaches in different regions of the same country.

Adopting and using the Consensus Statement is an opportunity for policy-makers to:

- review current policy and practice;
- be clearer about why current priorities are in place;
- where necessary, set an agenda for action that sets and guarantees minimum standards of services for people misusing drugs.

This Consensus Statement recognises that the law around possession and distribution of drugs varies considerably from one country to another. There are also considerable variations between countries in the options that are available to the police and the courts when responding to a person who is found to be unlawfully in possession of, or distributing, any of these drugs.

The Statement asks policy-makers in each country to consider the range of reasonable options now available to the police and the courts, which could ensure an appropriate balance to be found between each person's health and social care needs on the one hand, and the need for deterrence on the other.

The structure of the Consensus Statement

The Consensus Statement is organised into four main parts

PART 1: Principles for working with prisoners who are (or have been) misusing drugs

PART 2: Policy and practice throughout the criminal justice process

This is arranged around

- the different stages an offender or prisoner can pass through within the criminal justice and prison systems;
- cross cutting issues concerning groups such as women or younger offenders.

PART 3: Cross cutting issues and special needs

PART 4: Checklists for key staff and governors/managers of prisons

PART 1 Principles for working with prisoners who are (or have been) misusing drugs

1. General principles

1.1 **We recognise that misuse of drugs in prisons reflects misuse of drugs in wider society.** For example, in prisons, as in the community, there is an increasing tendency towards poly-drug use, including a wide range of substances (e.g. cannabis, medicinal drugs diverted from their proper use, alcohol etc). It follows that any programme in prison should be complementary to that available in the community.

1.2 **We recognise that people move between prisons and the community.** This movement of people means that diseases being transmitted within prisons are often acquired in the community and will spread back into the community. Public health protection in the community depends on the provision of appropriate health services to people in prison.

1.3 **We recognise that imprisonment as a punishment extends only to deprivation of liberty.** Prisons should not add to that punishment by also depriving people of other human rights, such as access to health care equivalent to that available in the community, or exposure to greater risks to their health than they would face in the community.

1.4 **We recognise that prisons must be safe, secure and decent places in which people are living and working.** The health, safety and welfare of all prisoners and staff depend on there being clear rules, clear procedures, and clear sanctions for people who try to operate outside of these boundaries.

1.5 **We recognise that many prisoners are socially and economically excluded people,** often with complex problems around their psychological well-being, health, and relationship with their families. These factors are often associated with misuse of a wide range of psychoactive substances.

1.6 **We recognise that people working in prisons must work with the law as it stands.** The criminal law around the wide range of misused substances varies from one state to another. For example, the ages at which alcohol may be legally purchased and/or consumed differs considerably across

national boundaries. From time to time there are debates about changes in laws relating to some drugs. But prisons must enforce whatever the current legal position happens to be.

1.7 **We recognise that a range of criminal behaviours can be associated with the misuse of drugs.** Some people are in prison because they were (or are suspected of having been) in possession of, and/or distributing, and/or misusing illegal substances. Others have been imprisoned because they were (or were suspected of) committing an acquisitive crime, which might have been motivated by the need to fund a drug habit, or because their judgement was affected by the pharmacological action of drugs. Some people can also be imprisoned because of involvement (or suspected involvement) in crimes of violence and intimidation, associated with some of the illicit ways in which drugs are distributed in the community. Helping people deal with issues around drug misuse is therefore not only important to their health and social care; it is also a way of reducing their likelihood of being involved in future crime.

1.8 **We recognise that responses from the criminal justice system to people misusing drugs must take account of the ways in which they have breached the criminal law, as well as addressing their health and social care needs.** An appropriate balance is more likely to be achieved where decision-makers keep themselves and the public well informed about the health and social care and criminal justice aspects of drug misuse. Often, health and social care interventions for substances whose use is legal in the community (e.g. alcohol in most contexts) resemble those for illicit drugs.

1.9 **We recognise that health professionals alone cannot tackle the problems of drugs in a prison context.** A multi-disciplinary approach is necessary. For example, people misusing drugs may need help in the form of counselling, information and education, and assistance with housing, learning, employment and finance issues on release. There is a need for prison managers and officers to ensure that appropriate security measures are in place to minimise the possibility of drugs getting into prison.

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1.10 **We recognise that appropriate harm reduction measures are essential, to reduce the incidence of damage to health associated with the misuse of drugs.** Examples include the transmission of infections, such as HIV and hepatitis, and also violence, coercion and sexual abuse which can be associated with the illicit ways in which drugs are distributed in prisons. We also recognise that there can be tensions between some harm reduction measures and other issues around the running of a prison, such as security, criminal justice and occupational health. These tensions are likely to be resolved in very different ways in different countries and settings. *This is discussed further in a later section of this Consensus Statement.*

2. Principles about the provision of services in prisons

2.1 **We affirm that there should be health services in prisons which are broadly equivalent to health services in the wider community.** This principle of equivalence suggests the offer of services which:

- are based on assessed need. People in prisons are likely to have higher levels of health care need than many people in the community, as they are more likely to be from socially excluded and economically deprived backgrounds;
- support people in overcoming drug dependency;
- involve each prisoner as a partner in planning and taking responsibility for his/her care and treatment;
- prevent the spread of communicable diseases;
- promote healthy habits (including, for example, smoking cessation service provision); and
- reduce the personal and environmental harm resulting from high-risk behaviours.

2.2 **We affirm the importance of professional ethics in the provision of all health care**. One important aspect is the **principle of autonomy**, recognising the right of patients to be fully consulted about medical interventions (including the

possibility of refusing care), and the importance of health care staff being professionally independent of prison management and able to undertake their duties according to the ethical guidance of their professional organisation. Members of different professions need to consider how best to manage the tension between client confidentiality and multi-disciplinary working. Some multi-disciplinary teams ask clients to give informed consent to the sharing of relevant information in specified circumstances.

2.3 **We affirm that ethical care implies evidence-based care** and that this should apply equally within prison and outside. Giving priority to further research into what works best is essential as a way of developing more effective services. It is important to ensure that where prisoners are taking part in research, proper regard is had to the ethics of consent and confidentiality.

2.4 **We affirm that service provision should be efficient and effective**. This can be achieved when services are planned on the basis of needs assessment, are evidence based, feature clear responsibility for delivery, and entail documentation of individual treatment and support plans which have clear objectives and are regularly monitored and reviewed. Overall outcomes should be evaluated as part of a regular review of the whole service.

2.5 **We affirm the importance of ensuring that there is continuity of care**. People with issues around substance misuse who move between prison and the community can find short periods in prison very disruptive to their community based treatment and support programmes. There must be **real co-operation between prisons and external agencies** to address the needs people have, both when they go into prison, and when they leave it. This must be an integral part of the health care strategies for those with drugs problems in prisons.

2.6 **We affirm the importance of providing all prisoners and prison staff with information and education about drug use and the risk of communicable disease**. It is important to recognise the contribution that a good prison health service can make to public health as a whole. Information is often available from organisations based in the community. It can be

disseminated in a number of ways in prisons e.g. distribution of leaflets, and discussions in peer support groups. The latter are especially useful for people who may have difficulty in reading written material.

2.7 **We affirm the importance of taking all reasonable action to reduce the supply of drugs inside prisons**, thereby minimising prisoners' opportunities to use them, encouraging prisoners to take the option of treatment, and also reducing the harm that can be associated with their illicit supply (e.g. bullying, extortion and loan rackets – with their implications for mental health promotion – as well as such public health issues as the spread of infections through shared injecting equipment). Prescribed medication is sometimes misused, so reducing the supply of drugs should include providing effective systems for controlling the availability of prescribed medicines.

2.8 **We affirm the importance of taking all reasonable action to reduce the demand for drugs in prisons**. The provision of comprehensive assessment, treatment and aftercare services supports prisoners in their efforts to stop misusing drugs, and thereby reduces the demand for them.

2.9 **We affirm the importance of addressing each prisoner's drug treatment needs in the wider context of working with him/her to address his/her offending behaviour**, thereby reducing the risk of re-offending, **and to encourage him/her to reduce risks to his/her health** by adopting harm reduction strategies.

This Statement has based its recommendations on the above principles and also on the accumulated experience of the network of European nations working together in the WHO Health in Prisons Project and with the Pompidou Group of the Council of Europe.

PART 2 Policy and practice throughout the criminal justice process

We believe that policies and practices are best understood in relation to stages in the person's contact with the criminal justice process. Each of the stages provides opportunities for intervention.

These stages may include:

1. arrest and police custody on suspicion of a criminal offence;

2. possibility of diversion into treatment programmes or community facility;

3. entry to prison;

4. time on remand (awaiting trial), either in prison or in the community;

5. time spent in prison, if so sentenced by a court;

6. preparation for release;

7. release into the community;

8. aftercare in the community.

After these have been discussed in turn, several cross cutting issues are also considered.

The stages of contact with the criminal justice process

1. Arrest and police custody

All member states have laws which make possession and/or selling of some substances a criminal offence and many drug users are arrested from time to time. For example:

- they may be arrested for possession or dealing;

- many drug users find that it can be difficult to obtain sufficient funds to pay for supplies, so they become involved in other, acquisitive, criminal activities.

In addition, a significant proportion of offenders are also consumers of psychoactive substances (including alcohol), whether or not this is related to the offences committed.

Our policy at this stage is to make best use of this identification of a person using drugs to assess the appropriateness of the various options available.

Practices which can support this policy may include:

- ensuring that police and social services staff know what options exist;

- having custody health care professionals at police stations, working alongside other staff, to assess newly arrested people for a range of health and social care needs (including effective treatment of any overdose or withdrawal symptoms, and ensuring continuity of any previously started treatment), and to identify possible interventions available from community and prison based agencies;

- ensuring that police officers are trained to identify early signs of drug use so that they can make appropriate referrals to such custody health care professionals;

- having outreach workers from a range of drug agencies visit police stations to take referrals from police officers and/or health care professionals. There may be occasions when a newly arrested person is already one of their clients, in which case they can provide continuity of treatment in the light of the client's changed circumstances;

- ensuring that the range of agencies involved are developing ways of working together which maximise awareness of one another's roles, and support referrals and the appropriate flow of information.

2. Court appearance and possible diversion into treatment programmes

Our policy is to recognise that it is important to use the drug user's experience of arrest and court appearance as an opportunity to encourage him/her to address his/her habit and his/her associated criminal behaviour.

Practices which support this policy may include:

- prosecuting authorities having the discretion to decide not to prosecute on the basis that the person is making positive progress on a health and social care programme that is addressing his/her drug use and related criminal activity;

- courts being empowered to underwrite drug users' co-operation with health and social care programmes by making their continued co-operation a condition of not being punished for proven offences;

- ensuring that such programmes form part of wider community based sentences, such as probation orders, community service orders, part-time attendance at detention centres, and fines.

3. Entry to prison

Our policy is that:

- prisons should make all reasonable efforts to ensure that prisoners do not have access to any drug, from whatever source, that has not been legitimately supplied for their personal medical use. This includes alcohol;

- prisoners should be fully assessed so that those who no longer have access to their drug of choice (including alcohol) can be identified, and so that appropriate health and social support can be offered to them;

- information should be provided to all new prisoners about drugs, and about the importance and availability of harm reduction measures;

- prison staff should be aware that people who may not have used drugs before might start to use them whilst in prison.

In addition to needing support in coping with the shock of having been admitted to prison, prisoners who have been using drugs will also need support with no longer being able to access substances in the way they had been doing in the community. This support should address **physical dependence** and **psychological dependence**.

Physical dependence

A number of strategies can help here. These include the following options:

Detoxification:		through pharmacological and/or other therapies, the person is helped to reduce physical dependence on substances that they have been using.
Substitution:		the person is helped to reduce physical dependence on one substance by being introduced to the use of an alternative[20]. This sometimes forms a stage in a detoxification programme. With other patients it might be part of a longer-term strategy of maintenance.
Maintenance:	EITHER	the person is helped from reverting to the use of a substance by receiving clinically prescribed maintenance doses of a substitute substance.[21]
	OR	the person is helped to reduce and control their use of a substance by receiving clinically prescribed maintenance doses of the substance.[22]

[20] e.g. substituting methadone for heroin.

[21] e.g. providing maintenance doses of methadone as an alternative to heroin.

[22] e.g. providing maintenance doses of heroin. However, although there is an evidence base for this in the community, the evidence base *in the prison setting* is lacking; what does exist is a report of positive results from a small trial in two prisons in Switzerland.

Legal issues and professional guidelines around some of these options vary from one country to another.

Psychological dependence

Programmes of psychological and social care are often needed to address this long after physical dependence has either been overcome or stabilised. These are discussed in Section 5.

Practices which support this policy at the point of entry into prison:

- whatever services are made available within prisons, it is important that new prisoners are assessed for which options are most appropriate to their needs. It is especially important that people who were already involved in a community based treatment should continue to receive a service that is as similar as possible while they are in prison. It is unlikely to be appropriate or lawful for people, whether or not they are in prison, to be treated for substance dependency without their consent, except where they are officially recognised as being mentally ill;

- as some prisoners might be reluctant to disclose their use of drugs in the community, it may be appropriate to consider testing the urine of all new prisoners for traces of drugs, as part of the initial health care assessment process. It is extremely important, where such tests are undertaken by health care staff, that the results remain confidential to the health care team;

- continue to monitor prisoners after they have first been received, so that those whose drug use has been missed on arrival, or who start to use drugs while there, can be identified and offered appropriate services;

- offer a planned programme for detoxification for people with a history of misusing drugs and/or alcohol, with trained staff and followed where appropriate by supervised abstinence;

- provide an environment where pressures for continued drug use are reduced, such as drug free areas within the prison, where inmates can volunteer to be located and supported by a programme of voluntary drugs testing;

- provide programmes of social and psychological care, which might include peer support schemes;

- use a supervised programme of prescription of a substitute drug such as methadone or Lofexidine, as part of a detoxification programme;

- use methadone as part of a long-term maintenance programme;

- introduce action to reduce harm arising from toxicity caused by overdose and/or contaminants and/or infections of various kinds (see later section on harm reduction.)

4. Time spent awaiting trial, either in prison or in the community

In many countries there can be several court hearings before it is decided whether a person is guilty of an offence, and, if so, what would be an appropriate sentence. Often, at each hearing it will be decided whether the time spent awaiting trial should be spent in prison, or in the community. Someone going through this process may have to go in and out of prison at short notice.

Our policy is that:

- programmes of health and social care provided to people in these circumstances should link up – it is important that each person experiences continuity of care, regardless of major changes in their circumstances;

- there must be recognition that this can be a very anxious time increasing the likelihood of substance abuse. There is also the possibility of serious self harm, or even suicide, if the person feels unable to cope.

Practices which support this policy are likely to include those listed in section 3.

5. Time spent as a sentenced prisoner

Time spent in prison should be used as an opportunity to work with all prisoners on their offending behaviour and on their continuing health

care needs which should include systematic identification of those with problems of substance misuse. Sup

Many prisoners will continue to need access to those services that have been described in earlier sections of this Consensus Statement.

Once a person has been sentenced to a period of imprisonment, it is possible for him/her, and people working with him/her, to plan how the time can be used to address identified needs. Often, the time scale involved will mean that physical dependence is already being addressed, and that it is now appropriate to consider how best to tackle psychological dependence. Sup Sup Sup

Our policy is that:

- as part of sentence planning, care plans should be developed, in consultation with the prisoner, which build upon and continue work already started;

- there should be help and encouragement for the prisoner to face up to his/her use of drugs and his/her engagement in criminal behaviour as part of the wider issues s/he is facing and his/her future life plans.

Practices which support this policy may include:

- ***for the whole prison***

  - provision of purposeful activity to provide meaning and motivation e.g. education, employment whilst in prison, and preparation for employment on release; Sup

  - continued security measures to minimise the supply of illicit substances in the establishment;

  - availability of drug free areas within the prison, supported by voluntary testing programmes;

  - mental health promotion support (see WHO HIPP Statement on mental health promotion in prisons);

  - health promotion, education and harm reduction measures;

- where possible, provision of opportunities for a range of purposeful activities e.g. employment, education, opportunities to take part in culturally appropriate creative activities and involvement in drugs education programmes.

- ***for staff***

  - drugs (including alcohol) awareness training;

  - encouragement of working in conjunction with specialist and health care staff, based on ethical principles;

  - awareness of principles of health promotion.

- ***for individual prisoners***

  - continuing assessment of, and programmes addressing, individual needs and motivation;

  - provision of services such as counselling;

  - facilitation of peer support schemes;

  - provision of advice about and means for reducing harm associated with drug use (see discussion later);

  - possibility of being able to transfer from prison to live in a therapeutic setting, where this is assessed as being clinically appropriate;

  - ways might be found to enable prisoners to maintain links with families, both as a means of support during imprisonment, and to enable more effective resettlement on release.6. Preparation for release

Our policy is that:

- he/she will need to be told and to fully understand that it is dangerous and often fatal to return to doses that may have been used and tolerated by one's body prior to imprisonment;

- preparation for release should start at the beginning of a person's time in prison;

- it is important that the person experiences continuity of treatment once they are back in the community;

- the prisoner should understand the importance of continuity of treatment and support;

- he/she will need encouragement and support in not returning to community based sources of supply, and drug using subcultures.

Practices which support this policy may include:

- education about the risks and means of preventing overdose on release;

- provision of support in searching for appropriate housing, employment, primary health care and continuing education;

- encouragement to maintain or refresh links with families and other supportive networks.

7/8. Release and aftercare

Our policy is to recognise that this is a testing time for prisoners, as they will face:

- pressure to re-engage with the same opportunities to obtain a range of drugs as before their arrest, drugs which will be more easily available than when they were in prison – carrying with it the risk of overdosing after a period of abstinence or reduced usage;

- challenges, prejudices and frustrations as they seek accommodation, employment and appropriate social networks.

Continuing care in the weeks following release is essential to the efficacy of the work started in prison. If the progress made whilst in prison is not supported when the person is released, then s/he is likely to start using drugs again. Cumulatively, this will increase public health risks and levels of crime in the community.

Practices which support this policy should aim at empowering the person to successfully deal with a range of new opportunities and challenges. These practices can include:

- ensuring that appropriate referrals have been made to community based agencies thereby enabling continuity of support and treatment;

- active involvement of the prisoner in his/her resettlement planning. This might include the possibility of the prisoner being able to have some contact with post-release support agencies while still in prison;

- helping prisoners to access accommodation, with appropriate support services, after release.

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PART 3 Cross cutting issues and special needs

A number of issues are relevant to all the stages identified above. Where this section considers the needs of particular groups of prisoners (e.g. women), it is important to bear in mind that any special arrangements suggested here would be in addition to the measures relevant to all prisoners, that have already been described above.

1. Staff training and support

Our policy is that everyone working with prisoners, or with former prisoners, should have an awareness and understanding of the work being undertaken by colleagues both in prisons and in a range of community based agencies. This is vital if services are to be joined-up.

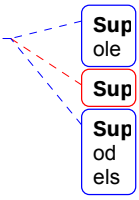
Practices which might support this policy

- In many prisons there is a need to encourage staff to see health and social care interventions as an important and central part of the work that prisons must do if they are to support resettlement and reduce the risk of people committing further crimes after they have been released.

- Providing training for staff in groups drawn from a range of disciplines and agencies (both within and beyond the prison) helps to encourage wider perspectives, mutual understanding and multi-disciplinary working.

- Staff whose primary role is the day-to-day supervision and management of prisoners will need to have drugs awareness training so that they can understand the scientific basis of addiction and its treatment, and can work in partnership with drugs workers. Similarly, drugs workers need to have an understanding of all aspects of the regime in the prison where they are based.

- Staff training and personnel policies need to raise awareness that staff are often role models for prisoners. For example, prisoners are aware of any staff who happen to use even small amounts of alcohol before work or during breaks. This behaviour can be used to justify (to themselves and to others) their own use of a range of substances. It follows that any staff who have problems with alcohol must have ready access to support in addressing their problems. Similarly all staff need to be aware that sometimes colleagues may themselves be using drugs, and could be at risk of being pressurised or tempted to supply drugs to prisoners. It follows that any staff who are misusing drugs must have ready access to support.



2. Women

Our policy is to recognise that:

- there is a more significant proportion of women than men in prison, whose offence can frequently be related to the misuse of drugs;

- that similarly a significant proportion of women entering prison are in need of detoxification;

- women who misuse drugs have specific health care needs, particularly those who are also pregnant;

- some women fund their misuse of drugs through prostitution in the community;

- some women in prison have had risky relationships with male intravenous drug users;

- women are, more often than men, the primary carers of children, and this has implications for the health and social care needs of both the women and their children.

Practices which support this policy may include:

- providing specialist advice on treatment of pregnant women who are using drugs;

- providing appropriate health and social care for mothers and babies if they are living together in prison;

- providing appropriate health and social care for imprisoned women's children who are living in the community. This should include assessing, while putting the interests of the child as paramount, the appropriateness of maintaining contact with their mother in prison;

- providing education on relationships, sexual health (including contraception,) and harm reduction to women in prison.

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3. Young people

Our policy is to recognise that young people are still developing and have special needs. For example:

- many young people are still developing life and social skills;

- families and other supportive networks can be especially important sources of support;

- there is a growing number of young people who are, or who have been, misusing drugs and/ or alcohol;

- some youth cultures encourage use of a wide range of substances in an experimental and risky way.

Practices which support this policy may include:

- the inclusion of drugs and alcohol awareness training in education programmes;

- ensuring that education programmes address identified needs for skills development (e.g. literacy, numeracy and self-care);

- provision of physical activities;

- linking up with community based youth and social services when developing services which prepare young people for release and which help them to find appropriate housing, training and employment opportunities;

- establishing schemes which encourage young people to maintain or revive contact with their families;

- encouraging culturally appropriate group activities, peer-led education and positive role models for young people, especially when trying to develop self-responsibility.

4. Ethnic minorities

Our policy is to recognise that members of ethnic minorities can face additional major problems which may require positive intervention. For example:

- racial prejudice and discrimination, which can undermine effective resettlement, self-esteem and well-being must be combated;

- where language and culture are not the same as the main ones in the country in which they have been imprisoned, there should be special measures to ensure they are not disadvantaged;

- their attitudes and understanding of issues around the use of drugs and alcohol may not be the same as that of other people living in the country of imprisonment.

Practices which support this policy can include:

- prison managers and staff finding ways of challenging and tackling any racism in their establishments;

- providers of community based services must also ensure that all aspects of their practice are free from discriminatory attitudes and practice;

- providing additional support in accessing housing, employment and training, as these are areas where considerable discrimination can often be experienced;

- providing support with education, including language tuition, where appropriate;

- providing diversity awareness training for members of all groups of staff and prisoners.

5. People who have been imprisoned while visiting/working in another country

Our policy is to recognise that these prisoners can face major additional problems. They can include people who have been carrying drugs whilst travelling from one country to another. These prisoners are often required to return to their countries of origin when they are released, and this clearly limits the extent to which preparation for release can fully achieve continuity of health and social care.

A practice which might support this policy – where prison managers identify that they are regularly dealing with groups of people from particular places, it may be helpful to establish links with community based agencies in those countries, as a way of developing some continuity of care after release and relocation.

6. Harm reduction

As set out as a General Principle, **our policy is that** appropriate harm reduction measures are essential, to reduce the risk of a wide range of damage to health that can be associated with the misuse of drugs. Examples include:

- the transmission of infections, such as HIV and hepatitis – which have serious implications for the wider community as well as the individual prisoner;

- the effects on health of violence, coercion and sexual abuse which are associated with the way in which drugs are supplied and paid for in prisons; a particular risk in this regard is the transmission of sexually transmitted infections;

- the risk of overdose;

- the risk of using contaminated drugs;

- the risk of side effects from misused substances.

We also recognise that there can be tensions between some harm reduction measures and other issues important to the running of a prison, such as security, criminal justice and occupational health considerations. These tensions are likely to be resolved in different ways in different countries and settings. Variables can include:

- resources available;
- types of prisoner involved;
- size and security level of the establishment;
- legal and cultural context;
- economic context.

Practices which may support this policy

Reducing harm associated with transmission of infections

The principle of equivalence suggests that a range of harm reduction measures might be put in place in prisons, similar to those provided in the community. Measures in the community include confidential testing with pre- and post-test counselling, effective treatment, public information campaigns, personal information and counselling, group education on safer drug use and safer sex, peer education and peer led initiatives, vaccination against those viruses where such vaccines are available and approved (e.g. Hepatitis B), advice on using bleach or other disinfecting methods to clean needles and syringes, the provision of sterile needles and syringes, and the provision of condoms.

A number of countries are already providing a wide range of health education programmes and harm reduction advice to prisoners. A number are also offering prisoners vaccination against Hepatitis B. In many countries, hepatitis infection amongst prisoners with a history of intravenous drug use is now more prevalent than HIV infection.

As identified above, the provision of services in prisons must take account of their legal, social, economic and cultural context. This context enables prisons to offer some options which are not available in the community, such as drug free wings where prisoners volunteer to be located away from the pressure of dealers, and to be tested

regularly as a means of ensuring that the area remains truly drug free.

The custodial context also results in a range of views around harm reduction measures such as needle exchange.

Currently there are syringe exchange schemes in 20 prisons in Europe (in Switzerland, Germany, Spain and Moldova), which form part of comprehensive drug strategies in those establishments. The prisons use a range of models. For example, in Centro Penitenciario de Basauri men's prison in Spain the syringes can only be exchanged through contact with a specific member of staff, as this provides an opportunity for other matters to be raised. At Hindelbank women's prison in Switzerland, and Vechta women's prison in Germany, drug counselling contact is separated from the process of exchanging syringes, through the use of slot machines in residential areas. At a prison in Moldova, syringes are distributed by volunteer prisoners who are taking part in a peer support scheme. In Switzerland, the Ministry of Justice has responded to the evaluation of these schemes by advising that such programmes are legal and necessary. One canton (Berne) now requires needle exchange schemes in all its prisons.

The evaluation studies report that needle exchange programmes can be useful as an integral part of a general approach to drug and health services in prisons. Where they are provided there should also be other services which include health promotion measures, counselling, drug-free treatment and substitution treatment. The studies suggest that successful implementation depends on ensuring that systems are put in place which guarantee the maintenance of confidentiality and the assurance of health and safety arrangements for everyone working in the prison. Successful implementation also depends on being able to gain acceptance of the practice amongst prison staff, prisoners themselves, professionals, legal authorities and the general public.

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In contrast, there is also the view that needle exchange schemes can send out ambivalent messages about the use of illicit drugs. Some countries make disinfecting tablets available to prisoners as a way of trying to balance the difficult tension between health promotion and security issues. Others consider it important to provide these alongside any needle exchange programme.

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It is important that all policy-makers addressing issues around the use of drugs in prisons should remain informed of different developments in this area, and should regularly review their harm reduction policies and practices.

Reducing other drug related harm

Much harm can be reduced by providing prisoners with services which support them in not using drugs, or in using them (or substitutes) in a clinically structured manner, as described elsewhere in this Statement.

It is also important that staff training programmes cover how staff can protect themselves from harm, and that staff be provided with appropriate equipment to be able to do so.

Policies and practices should in any case be in place to address issues such as violence, coercion and sexual abuse, as these can also arise for reasons not connected with the distribution of drugs in prisons. Guidance on this has been provided in the Health in Prisons Project's Consensus Statement entitled *Mental Health Promotion in Prisons*, which was agreed at a Conference in The Hague in November 1998.

7. Co-morbidity

Our policy is to recognise that prisoners who use drugs often have other physical and/ or mental health problems. Some of these may be related to drug misuse, e.g. infections acquired through contaminated needles or self neglect related to the diversion of funds from the acquisition of food and fuel to the acquisition of drugs. Sexual health problems, arising from relationships with intravenous drug users who are themselves sharing needles, or from undertaking paid sex work as a means of funding the acquisition of drugs, should also be seen as problems relating to drug misuse. Others can be the result of side effects of substitute medication (e.g. many people using methadone develop dental problems). It has also been noted that drug misuse (including alcohol) can often be associated with mental health problems such as depression or psychosis. It is not currently clear whether this association might involve a causal link. It is important that care and treatment programmes holistically address the full range of health and social problems faced by people who are misusing drugs.

Practices which might support this policy

- comprehensive health assessment and monitoring;
- liasing with previous health care providers to ensure that information about previously identified health problems and treatment programmes is obtained;
- liaison between different groups of professionals who may be involved in different aspects of a prisoner's health and social care;
- provision of dental, mental health and sexual health services in prisons.

8. Monitoring and evaluation

There is a need for evaluation of programmes and approaches that are being put into practice, which would provide an evidence base for the development of Standards.

PART 4 Checklists for key staff and governors/managers of prisons

1. Checklist for local health care providers

People in custody come from the community and will return to the community. Public Health depends on the provision of effective health services in custody, and on continuity of care when people leave it.

The following measures may help local health care organisations to provide effective services to people leaving custody who have been using drugs:

1. Developing links with police stations, courts and prisons, enabling referrals to be made by staff working in them;
2. Where prisons, courts or police stations do not have any health care staff, considering what input might be offered to them;
3. Meeting with health care staff from prisons and police stations to establish protocols for information exchange which would support continuity of treatment as people move in and out of

custody and to exchange information on developments in practice;

4. Ensuring that the special needs of women, young people and members of minority ethnic groups are addressed;

5. When gathering information and routine data on the health needs of the local population consider including prisoners as an important part of your local population.

2. Checklist for prison managers

Public health depends on the provision of effective health services in custody, and on continuity of care when people leave it. Prison provides an opportunity to address a wide range of health problems, including those associated with drug misuse.

The following measures may help prison managers to provide effective services to prisoners who have been using drugs:

- Give consideration to the checklist contained in WHO Health in Prisons Project's *Mental Health in Prisons* Consensus Statement, which provides guidance on measures to deal with bullying and intimidation in prisons, as part of a wider recommendation on promoting health in prisons;

- Develop links with police stations, courts and community based health providers, enabling referrals to be made to prison based health care staff;

- Meet with health care staff from police stations and community based health providers to establish protocols for information exchange which would support continuity of treatment as people move in and out of custody, and to exchange information on developments in practice;

- Ensure that all staff are trained so that everyone working in the prison has an awareness of the issues around drugs and can understand their role in a multi-disciplinary approach. Ensure that this training includes coverage of harm reduction measures, both for prisoners and for staff;

- Arrange meetings between groups of staff in the prison to encourage multi-disciplinary working;

- Ensure that health care staff are able to follow ethical principles in their work;

- Consider and review the extent and appropriateness of harm reduction measures in the prison, both for staff and prisoners;

- Consider and review the extent and appropriateness of procedures to identify and assess people who are misusing drugs (including alcohol) when they first enter prison;

- Consider and review the extent and appropriateness of health and social services provided for prisoners who have been (or who are) misusing drugs (including alcohol);

- Develop a policy on smoking which would move the prison towards a position where all prisoners and staff can choose to live and/or work in a smoke free environment;

- Ensure appropriate provision of services for people with mental health problems, and those who have dental and hygiene problems;

- Ensure that the special needs of women, young people and members of minority ethnic groups are addressed;

- Consider how patterns of drug use might be monitored with a view to this information supporting the development of appropriate services;

- Ensure prisoners have adequate information (through education as well as in written form) on drugs, including their effects, risks to health, harm reduction, and relevant services on offer in the prison and on release;

- Ensure that copies of this Consensus Statement are available to both health care and other staff working with drug users and is available in the prisoners' library (if there is one);

- While encouraging each prisoner's sense of responsibility through appropriate systems for individual self care, consider the need for effective control of prescribed medicines to reduce the potential for diversion and misuse. (However, this should in no way restrict the principle by which prescribing medication is the responsibility of the medical services.)

Appendix I: Programme

Thursday, 20 September 2001

10.30 – 14.00 Registration

14.00 – 14.30 Opening Session

- The Federal Office of Public Health
  Professor Thomas Zeltner
- Council of Europe, Pompidou Group
  Mr Christopher Luckett
- World Health Organization, Regional Office for Europe
  Dr Roberto Bertollini

14.30 – 15.30 Plenary Session 1

A review of the general context

- Drugs and society
  Dr François van der Linde (Switzerland)
- The prison, today and tomorrow
  Baroness Vivien Stern (United Kingdom)
- Drugs in prisons, the realities
  Mr Harald Spirig (Austria)
- HIV in prison
  Dr Paola Bollini (Italy)

15.30 – 16.00 Break

16.00 – 18.00 Parallel Working Groups
On the Consensus Statement

Evening social function

Friday, 21 September 2001

09.00 – 10.30 Plenary Session 3

The size and nature of the problem

- The problem in the West
  Dr Heino Stöver (Germany)
- The problem in the East
  Dr Alexander Gunchenko (Ukraine); Dr Marzena Ksel (Poland)

Efficacy of health strategies

- Prevention and treatment
  Professor Ambros Uchtenhagen (Switzerland)
- Risk reduction strategies
  Dr Michel Rotily (France)

10.30 – 11.00 Break

11.00 – 12.30 Plenary Session 4

The role of key actors and facilitators

- The judiciary
  Professor Paul Vegter (Netherlands)
- The role of the media
  Dr Franklin Apfel (WHO)
- The prison governor
- The staff
- The medical staff
- The prisoner
  Mr Mark Leech (UK)

12.30 – 14.00 Break

14.00– Prison visits and testing of the draft Consensus Statement

Evening social function

Saturday 22 September 2001

09.00 – 10.30 Plenary Session 5

- Feedback from working groups
- Speakers' panel on working group reports

10.30 – 11.00 Break

11.00 – 12.00 Plenary Session 6

- The prisoner
  Mr Mark Leech (UK)

- Concluding Guidelines

12.00 Closure

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The first part of the publication contains information about the conference itself including some of the reports presented. The second part contains a consensus statement adopted at this occasion. The aim of this consensus statement is to encourage, where appropriate, effective change in policies and practices relating to prisons and drugs. It draws together in a European context the fundamental areas on which a general agreement has been reached.

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