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# STANDARDS FOR TREATMENT OF PEOPLE WITH DRUG USE DISORDERS IN CUSTODIAL SETTINGS

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

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## Abbreviations, Acronyms

| | |
|---|---|
| CPT | European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment |
| DUD | Drug use disorder |
| EMCCDA | European Monitoring Centre for Drugs and Drug Addiction |
| HIV | Human immunodeficiency virus |
| MAT | Medication assisted treatment |
| MoJ | Ministry of Justice |
| MoH | Ministry of Health |
| MOUD | Medication for opioid use disorder |
| NSEP | Needle/syringe exchange program |
| OAT | Opioid agonist treatment |
| OST | Opioid substitution treatment |
| OUD | Opioid use disorder |
| PHC | Primary health care |
| PDL | People deprived of liberty |
| PWDUD | People with drug use disorders |
| TB | Tuberculosis |
| UNODC | United Nations Office on Drugs and Crime |
| WHO | World Health Organisation |

## Introductory remarks

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

1) Drug use disorders are health disorders[1]

2) Health care for people deprived of liberty is a whole state responsibility[2]

3) People deprived of liberty have the right to the highest attainable standard of health[3]

4) Prison Health is Public Health[4]

1) implies that for implementing appropriate treatment systems for people with drug use disorders (PWUD) in criminal justice settings, not only health care staff but everybody responsible for persons taken hold of by the criminal justice system, including police, prosecutors, courts, judges, prison administrations as well as custodial and probation staff, needs to understand the nature of DUD as a health disorder based on physiological brain alterations rather than as a weakness of will or character or as criminal behaviour. Professional training and support for achieving this understanding is indispensable for the set-up of standards of drug treatment systems in the criminal justice system.

2) and 3) call for the commitment of state authorities in addition to the penitentiary administrations for taking over responsibility for providing health care to people deprived of their liberty (PDL)grounded on the facts that the state (and not the penitentiary administration) has taken away their liberty and that PDL are unable to realize their right on the highest attainable standard of health care themselves by the means at their disposal.

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

Therefore, for a set-up of standards for treatment of PWDUD taken hold of by the criminal justice system, the involvement of legislative bodies, jurisdiction, governments with line ministries and the respective administrations, in addition to detention and penitentiary institutions, governmental and non-governmental health care services and penitentiary services is necessary. Regardless of the pattern of healthcare governance the state has for

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[1] WHO, ICD-10, https://icd.who.int/browse10/2016/en#/F10-F19

[2] UNODC, WHO: Good governance of prison health in the 21st century. A policy on the organization of prison health, 2013. https://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

[3] International Covenant on Economic, Social and Cultural Rights 1966. https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

[4] WHO, Moscow Declaration on Prison Health as Part of Public Health, 2003. https://www.euro.who.int/__data/assets/pdf_file/0007/98971/E94242.pdf

[5] International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization and United Nations Office on Drugs and Crime; 2020. https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders

people in the criminal justice system, a close intersectoral cooperation is indispensable for adequate treatment of PWDUD in the criminal justice system both for care during application of non-custodial measures, during imprisonment and after release.

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

When discussing standards of treatment for PDL, it has become common, in accordance with the United Nations Standard Minimum Rules for the Treatment of Prisoners, to refer to “minimum standards”. However, in treatment of health disorders and in keeping with the principle of equivalence of care, i.e., the same quality standards of treatment for PDL as for patients in the community, the term minimum standards would not make any sense. Therefore, in this paper the author refers to the currently accepted standards of treatment for PWDUD as stipulated in the internationally consented documents listed in the Literature Review B and C (pages 24-26).

In keeping with the published international documents (see Literature Review A-C, pages 23-26), the background policies for developing standards of treatment of PWDUD in the criminal justice system should include:

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

## Drug use disorders

The recently published revised edition of the WHO/UNODC publication International Standards for the Treatment of Drug Use Disorders[6] presents a comprehensive explanation of drug use disorders (DUD):

> *According to the 11th revision of the International Classification of Diseases (ICD) (WHO, 2019a) the term "drug use disorder" comprises two major health conditions: "harmful pattern of drug use" and "drug dependence". The harmful pattern of drug use is defined as a pattern of continuous, recurrent or sporadic use of a drug that has caused clinically significant damage to a person's physical (including bloodborne infection from intravenous self-administration) or mental health (such as substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others. Substance dependence is defined in ICD-11 as a pattern of repeated or continuous use of a psychoactive drug with evidence of impaired regulation of use of that drug which is manifested by two or more of the following: (a) Impaired control over substance use (including onset, frequency, intensity, duration, termination and context); (b) Increasing precedence of drug use over other aspects of life, including maintenance of health and daily activities and responsibilities, such that drug use continues or escalates despite the occurrence of harm or negative consequences (including repeated relationship disruption, occupational or scholastic consequences and negative impact on health); and (c) Physiological features indicative of neuroadaptation to the substance, including: 1) tolerance to the effects of the substance or a need to use increasing amounts of the substance to achieve the same effect; 2) withdrawal symptoms following cessation of or reduction in the use of that substance; or 3) repeated use of the substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.*
>
> *"Disorders due to drug use" comprise a broader category of health conditions that include drug intoxication, withdrawal syndrome and a range of drug-induced mental disorders. Drug use disorders often go hand-in-hand with a significant urge to use psychoactive drugs, which can persist, or easily be reactivated, even after a long period of abstinence. Very often drug use disorders are associated with hazardous or harmful use of other psychoactive substances such as alcohol or nicotine, or with alcohol and nicotine dependence.*
>
> *The nature of the drug dependence is rooted in a complex dynamic interaction between biological, psychological and social factors. Neurobiological mechanisms range from inherited genetic vulnerabilities to disruptions of neuronal pathways in brain areas that regulate functions such as motivation, experience of pleasure, memory and learning (WHO, 2004; Koob and Volkow, 2016). Various psychosocial factors may increase the risk of both the initiation to drug use and development of drug use disorders. Family-related factors such as early childhood neglect, child abuse and parental modelling of substance use may contribute towards harmful patterns of drug use and drug dependence. At a societal or community level extreme poverty, displacement, favourable norms and media towards drug use have been shown to increase vulnerability to drug use disorders (UNODC, 2015).*

[6] International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization and United Nations Office on Drugs and Crime; 2020. https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders

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

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

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

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

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

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

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

## Standards in the legal framework

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

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

In addition, incarceration of PWDUD has been shown to considerably increase the risk of spreading transmittable diseases in prison and to the community[7] as a consequence of

[7] Dolan K, Wirtz AL, Moazen B, et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. Lancet 2016; 388:1089-1103. http://dx.doi.org/10.1016/S0140-6736(16)30466-4 and Altice FL, Azbel L, Stone J, et al. The perfect storm: incarceration and the high-risk environment perpetuating transmission of

temporary concentration of people with risk behaviour for transmission of diseases in an environment where preventive and therapeutic measures often are scarce or lacking and who eventually return back to the community.

Therefore, legal provisions for non-custodial sanction measures for offenders with PWDUD should be in place such as diversion by warnings, mediations, fines, restorative justice and referral to treatment. Organisational structures and resources for probation services and community sanctions should be established or strengthened. Sentencing practices for PWDUD offenders should resort to these structures to the maximum extent possible and, likewise, application of pre-trial detention should be reduced to the minimum extent possible which may need awareness raising in and training of judges. In addition, sentencing to these alternative, non-custodial measures should be exempted from inclusion on criminal records in order to avoid unintended negative consequences for future resocialisation and social rehabilitation of PWDUD.[8]There are ample international support and guidance for establishing these legal provisions, structures and practices. [9, 10,11 12,1314]

For health care and treatment of PWDUD in prison, health care governance in prison may play a crucial role in regard of professional independence of health care providers, a cornerstone for high-quality health care in prison. In addition to legal guarantees for clinical independence, health care governance taken away from the responsibility of penitentiary administrations and transferred to prison health departments subordinated directly to the ministry of justice (MoJ) or transferred to the ministry of health (MoH) or public health authorities, definitely increases clinical independence of health care providers from penitentiary administrations. A major part of European jurisdictions has legally and administratively undertaken these transfers in the last decades.[15] However, if the responsibility for the health of persons in the criminal justice system is transferred to the Ministry of Health, it must be ensured that their health needs are not given less priority than of those cared for in the community.

Appropriate legal regulations are also required for enabling internationally recognized and recommended[16] harm reduction and treatment measures for PWDUD in prison such as access

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HIV, hepatitis C virus, and tuberculosis in Eastern Europe and Central Asia. Lancet 2016; http://dx.doi.org/10.1016/S0140-6736(16)30856-X

[8] Bretteville-Jensen AL, Mikulic S, Bem P et al: Costs and unintended consequences of drug use control policies. Pompidou Group, Council of Europe Publishing 2017. https://rm.coe.int/costs-and-unitended-consequences-of-drug-control-policies/16807701a9

[9] Council of Europe: Recommendation CM/Rec (2017) 3 on the European Rules on community sanctions and measures; Recommendation CM/Rec (2014) 4 on electronic monitoring; Recommendation Rec (2003) 22 on conditional release (parole). All available at: https://rm.coe.int/compendium-e-2020-final/16809f3927

[10] United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules). https://www.ohchr.org/Documents/ProfessionalInterest/tokyorules.pdf

[11] Recommendation (2017)3 of the Committee of Ministers on the European Rules on community sanctions and measures, https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680700a5a

[12] Implementing Community Sanctions and Measures. Geiran V, Durnescu I. Council of Europe, 2019 https://rm.coe.int/implementing-community-sanctions-and-measures/1680995098

[13] Heard C, Fair H: Pre-Trial Detention and its Over-Use. Institute for Crime & Justice Policy Research, 2019, https://prisonstudies.org/sites/default/files/resources/downloads/pre-trial_detention_final.pdf

[14] European Union (16.12.19). Official Journal of the European Union (2019/C422/06). Council conclusions on alternative measures to detention: the use of non-custodial sanctions and measures in the field of criminal justice.

[15] Pont J, Harding TW: Organisation and Management of Health Care in Prison. Guidelines. Council of Europe, 2019. https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69

[16] UNODC, WHO Policy brief. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions, 2013. https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

to condoms and lubricants, needle/syringe exchange programs (NSEP) and permission for opioid agonists prescription in prison for programs of medication of opioid use disorders (MOUD).

In the case-law of the European Court of Human Rights, the international court of the Council of Europe hearing applications alleging that a contracting state has breached human rights according to the European Convention on Human Rights, violations of Art. 2 (Right to life) and Art.3 (Prohibition of torture) have been identified and member states sentenced because of lack or insufficient treatment of PWDUD in prison (see for example Keenan vs. UK, Mouisel vs. France, Kats and others vs. Ukraine, McGlinchey and others vs. UK, and Wenner vs. Germany [17]).

Recommendations of the Expert Group on the Regulatory Framework for the Treatment of Opioid Dependence Syndrome and the Prescription of Opioid Agonist Medicines[18] included the prescription and delivery of opioid agonists without prior authorisation schemes, the effective removal of financial barriers for patients undergoing treatment and the set-up of a national consultative body for coordination and monitoring, measures that definitely need adaptation of legal frameworks, particularly for MOUD in custodial settings.

Recent research on Naloxone administration by laypersons in life-threatening opioid overdose cases give reason to consider legally the permission to have this potentially life-saving medicine in opioid overdose emergencies administered by non-medical custodial staff during imprisonment and by laypersons after release from prison when no health professionals are present.[19]

## Ethics standards

Treatment for PWDUD is health care. Therefore, principles of medical ethics apply to treatment of PWDUD. There is a body of internationally consented principles of medical ethics specified for health care in prison enshrined in the documents as listed below in A) International standards and principles of providing health care in prison. Their common essence can be summarized as follows:

- The sole task of the health care providers in prison is the health and well-being of the inmates.
- Free access to health care for every prisoner
- Equivalence of and integration with community health care
- Patient consent and confidentiality
- Preventive health care
- Humanitarian assistance

[17] Guide on the case-law of the European Convention on Human Rights
Prisoners' rights, updated April 2021. https://www.echr.coe.int/Documents/Guide_Prisoners_rights_ENG.pdf

[18] Pompidou Group, Council of Europe: Opioid agonist treatment. Guiding principles for legislation and regulations, Council of Europe, 2017.
https://www.bing.com/search?q=Opioid+agonist+treatment+Guiding+principles+for+legislation+and+regulations&cvid=e0c6478a509c44b1a5da6767decef496&aqs=edge..69i57.1490j0j1&pglt=299&FORM=ANNTA1&PC=ASTS

[19] NCCH: Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths. NCCH, 2020
https://www.ncchc.org/naloxone-for-the-prevention-of-opioid-overdose-deaths

- Professional independence
- Professional competence

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

Respecting the first principle, the sole task of the health care providers in prison is the health and well-being of the inmates, implies that health care providers in prison are not involved in custodial measures such as drug testing for security reasons or in body searches or in any disciplinary punishment measures. It also implies that in the treatment of PWDUD the agreed-on treatment goals – both in the short and in the long run – are achievable for the individual patient and that the treatment provider's own ideas on human dignity and way of living do not sway the treatment goals set with the patient. It is the health and well-being of the inmate patient what is the task of therapy and not necessarily the adjustment of the patient's way of life to the therapist's life style.

The next two of the above listed principles, Free access to health care and Equivalence of and integration with community health care, stand for the access of imprisoned PWDUD to the same treatment and harm reduction options as accessible in the community, i.e., staffing or contracting properly trained therapists for DUDs, set-up of state-of-the-art treatment and harm reduction programs in prison, identifying PWDUD on admission and offering them the available programs. The equivalence and integration of treatment and harm reduction programs is also a safeguard for the indispensable continuity of care between prison and the community.

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

The crucial principles of patient consent and medical confidentiality play a major role in treatment of DUD. Consent of the adequately informed patient – "informed consent" – is a prerequisite to any treatment. There is no place for compulsory treatment of PWDUD because it amounts to a violation of human rights and has been shown to lack evidence of efficacy.[20,21,22]

Minimal requirements of information before entering a patient into a DUD treatment programme might include the following:

- Any obligation the physician has toward a third party that impairs confidentiality (notification to authorities according to the law or to the court) but also all those areas where the patient can count on strict medical confidentiality
- The rationale of the DUD treatment
- The obligations of the patient and the therapist as agreed
- The individual current treatment goal as elaborated with the patient
- Risks, unwanted side effects and possible restraints
- What is likely to happen if the patient deliberately stops treatment

[20] Stevens A. The ethics and effectiveness of coerced treatment of people who use drugs. Human Rights and Drugs 2012, 2: 7-15

[21] Werb D, Kamarulzamanc A, Meachamb MC, et.al. The effectiveness of compulsory drug treatment: A systematic review. Int.J.Drug Policy 2016, 28:1-9

[22] Lunze K, Idrisov B, Golichenko M, et al. Mandatory addiction treatment for people who use drugs: global health and human rights analysis: Table. BMJ, 2016; i2943 DOI: 10.1136/bmj.i2943

- How to deal with relapses
- What might cause the termination of the participation in the treatment

Treatment programs complex in medical, legal and psychological terms, such as MOUD, often do not only rely on verbal or written informed consent of the patient, but opt for a formal contract to be signed by the patient and the therapist. While a contract might add an element of coercion and mistrust to the patient-physician relationship, it underlines the agreed-on obligations of patient and therapist to be mutually reminded or demanded and, if explained and discussed properly, might enhance the understanding of the treatment program.

Medical confidentiality is not only a principle of medical ethics, it is an indispensable prerequisite for building up a trustful patient-health professional relation. PWDUD in prison may be interested to conceal their DUD for several reasons: they anticipate disadvantages in terms of placement, privileges and access to work; they fear prejudices and discrimination both by inmates and by staff and can become victims of pressure and blackmailing as soon as their drug dependence is known to others. When participating in opiate agonist medication programmes, they may become pressurized to divert the prescribed drugs to the black market in the prison. For these reasons every endeavour should be made to protect PWDUD in prison by maintaining good standards of confidentiality and by getting rid of discriminating regulations, behaviours and attitudes against them.

However, confidentiality for PWDUD in prison may be limited for legal and for practical reasons: e.g., for participants in MOUD, national law requires notification of persons who are prescribed opioids in most countries and the supply and delivery of opiate agonist drugs as well as the shortage of medical staff often requires the inclusion of and cooperation with security officers, a measure that impedes strict medical confidentiality. Comprehensive treatment of DUD in prison needs interdisciplinary cooperation where sharing of information and records is unavoidable and often in the interest of the patient. Every member of the treatment team is to be bound by professional confidentiality. It is of great importance that patients are well informed as to who will have access to their records, who is included in professional confidentiality and where are the de facto limitations of confidentiality.

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

Protective care for PWDUD by health care professionals relates to their particular vulnerability in prison: they rank low in the prisoner hierarchy, face prejudices by inmates and staff, run the risk of getting into debt with subsequent threats of bullying, violence, coercive sex work and pressure to divert prescribed drugs. A considerable proportion of PWDUD suffer from additional mental disorders (“dual diagnosis”) and need additional treatment, care and protection. Some of these problems can be avoided by confidentiality and providing appropriate treatment of their DUD but often sensible placement changes and additional protective measures may become necessary. Additional care and protection are also required for female and juvenile persons with DUD and for pregnancy and perinatal care of women with DUD. For pregnant women, mothers with young children, juveniles and children with DUD, imprisonment should be the very last resort and all non-custodial measures possible should be exhausted. The International Standards for the Treatment of Drug Use Disorders5, contains chapters on PWDUD with special treatment and care needs such as for women, for pregnant and perinatal care of mothers and babies and for children and juveniles including specificities on medication-assisted psycho-social treatment. In adolescents, a higher prevalence of

comorbid mental disorders than in adults must be taken into account. Whereas there is good evidence of age-appropriate psycho-social treatment in adolescents, there is very limited evidence of psycho-social and medication-assisted treatment in younger children.

A most important matter for treatment of PWDUD in prison is absolute professional, clinical independence of the health care providers. All clinical decisions, indication of treatment, kind and duration of treatment, kind and dosage of medication treatment etc., may only be taken by the responsible health care professional based on the individual assessment of the patient and mutual agreement and may not be overruled or ignored by non-medical prison staff. Treatment for DUD in prison is a medical treatment independent from custodial measures. This clarification is particularly important in those patients who are sentenced by the court to undergo treatment for addiction while serving their prison term.

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

## Treatment services and interventions

The UNODC/WHO International Standards for Treatment of Dug Use Disorders[5], based on currently available scientific evidence of ethical treatment for drug use disorders, set out a framework for the implementation of standards in line with principles of public health care that match the needs of PWDUD at all stages and severities of DUD consistent with the treatment of any chronic disease or health disorder. The Standards maintain a degree of flexibility to ensure their applicability in different social, cultural and legal frameworks, i.e., also in custodial settings the specificities of which one of the chapters of the Standards is dedicated to. The Standards are aspirational, and as such, national or local treatment services or systems need not attempt to meet all the standards and recommendations made in this document at once. However, over time, progressive quality improvement, with 'evidence-based and ethical practice' as an objective, can and should be expected to achieve better organized, more effective and ethical systems and services for people with drug use disorders.

Key aspects for the treatment of PWDUD are to be:

- effective: evidence-based according to scientific standards
- ethical:
  - consistent with Human Rights and UN covenants
  - promote individual and social safety
  - promote personal autonomy
  - builds on existing experience and standards

Treatment methods include:

- psycho-social therapy
- pharmacotherapy
- pharmacotherapy assisted psycho-social therapy

Goals of treatment:

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

Modalities of treatment programs should be:

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

## Treatment services and interventions in the criminal justice system

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

Treatment and interventions for PWDUD in prison raise the question of sufficient availability and qualification of treatment providers in penitentiary institution as well as the corequisite therapeutic environment.

In keeping with equivalence of care, if medically indicated treatments for PWDUD are not possible or available in prison, the individual must be referred to the appropriate outside medical services. This applies both to psychosocial treatment interventions and to medication assisted treatment such as opiate agonist treatment in withdrawal or maintenance therapy for people with opioid use disorders.

Staffing of adequately trained therapists for PWDUD by prison staff rarely if ever is sufficient in penitentiary systems and contracting trained therapists most often is inevitable. Quality of treatment for PWDUD is not dependent from the affiliation of therapists but from their level of qualification.

PWDUD undergoing treatment programs in prison ideally should be separated from the other inmates to reduce the risk of being exposed to drugs and relapse, to reduce their risk of becoming victimized and to maintain a therapeutic environment for them. Residential treatment such as therapeutic communities need to be conducted in dedicated units within the prison.

## Standards of treatment and interventions by primary health care professionals in prison

Although not specifically trained on treatment of PWDUD, primary health care (PHC) professionals play a central role in the care of PWDUD in prison. In general terms, their professional ethics should provide a guarantee for an ethical framework and professional approach for the care and treatment of PWDUD the same way as for any other patients with a chronic health disorder including advocacy for and supervision of preventive and harm reduction measures.

Primary health care physicians need to be trained in screening for and identifying PWDUD upon admission and their possible immediate need of treatment and frequent mental and physical comorbidities in order to arrange for immediate interventions such as treatment of withdrawal symptoms and prevention of self-harm and suicide and for referral to specialized treatment such as psychiatric care and treatment of infectious diseases.

Primary health care physicians in prisons not specialized in treatment for PWDUD still can and should engage in Screening, Brief Interventions and Referral to Treatment (SBIRT) of PWDUD according to the WHO/UNODC International Standards for the Treatment of Drug Use Disorders[5].

The screening for and identification of DUD in persons newly admitted to prison is the decisive prerequisite for all further steps of specific care and treatment of PWDUD. PWDUD may try to hide their disorder in fear of negative consequences, stigma, discrimination and victimization during imprisonment. The medical examination upon admission by the PHC professional needs her/his assurance of full confidentiality and patient's consent, privacy of the examination and building up trust for a sound patient/caregiver relationship to obtain honest patient histories. In addition, simple screening tools such as the WHO ASSIST screening test[23] may be used.

Brief intervention is a short, structured psychotherapy to be applied by general practitioners after relatively little training to people with drug use with the aim to empower and motivate them to take responsibility and change their substance use behaviour[24]. It follows a client-centred and clients' strengths-based approach trying to help patients reflect and develop skills and resources required to change, to set realistic goals, giving positive feed-back to the patient and to assess if further treatment is required. The components of effective brief interventions can be summarized in the FRAMES framework: Feedback is given to the individual about personal risk or impairment; Responsibility for change is placed on the individual; Advice to change is given by the provider; Menu of alternative self-help or treatment options is offered; Empathic style is used in counselling; Self-efficacy or optimistic empowerment is engendered. Brief intervention typically does not need more than 30 minutes duration.

Referral by the PHC physician to specialized treatment should occur whenever there is no sufficient response to the brief intervention or a clinically significant DUD or comorbid mental or physical health conditions in need of specialized treatment becomes apparent.

In some penitentiary systems general practitioners in prison have been trained to conduct successfully opioid agonist treatment for patients with opioid drug use disorders under the guidance and supervision of specialists in treatment of PWDUD, particularly as DUD specialists are not continuously available and opioid agonist treatment in patients with opioid use disorders has been shown to be effective even without accompanying psychosocial

[23] https://www.who.int/substance_abuse/activities/assist_test/en/

[24] Miller, W. R. and Rollnick, S. (2002). Motivational Interviewing: Preparing People for Change, 2nd edn. Guilford Press, New York.

therapy. However, whereas brief intervention requires comparatively little training for general practitioners, the complexity of opiate agonist treatment needs thorough training and licensing.

Primary health care professionals must be trained and equipped to manage medical emergencies of PWDUD upon admission and thereafter such as psychoactive drug withdrawal syndromes and intoxication, acute mental health disorder exacerbations and suicidality.

The primary health care unit of a prison should function according to the "one-stop-shop" approach for PWDUD, i.e., besides the general health care provision and preventive services such as vaccinations, harm reduction provisions, delivery and supervision of medication for comorbid conditions including HIV disease, hepatitis B and C, TB, mental disorders and medication for opiate use disorders (MOUD) if required, recognition and response to health crisis situations, it should serve as a gate keeper to specialized services such as psychological and psychiatric care, infection specialists, and social assistance and protection. The primary health care unit is also the place where the treatment documentation of PWDUD as a part of their confidential, individual medical record is kept.

## Standards of treatment by specialists for treatment of PWDUD

Specialized care services for PWDUD in prison – including medical, psychological, psychotherapeutic, social and educational care – must only be administered by personnel with the relevant qualifications and licences. If not available in prison, they must be contracted or delivered by civilian public or NGO facilities. Typically, they are either carried out by health and social care professionals specialized in the treatment of DUD, or more broadly within the context of mental health treatment and consist of a combination of psychosocial s and pharmacological interventions.

Any specialized treatment of PWDUD in prison should start with a thorough diagnostic assessment of the individual DUD patient evaluating the severity of drug and other substance use disorders and associated problems (including psychiatric, physical health and family issues). Useful evaluation instruments are the Addiction Severity Index (ASI)[25], Mini-International Neuropsychiatric Interview (MINI)[26] and the Composite International Diagnostic Interview–Substance Abuse Module (CIDI-SAM)[27]. Based on the professional individual assessment of each patient an individualized treatment plan needs to be elaborated with the patient to be regularly revised in the course of the treatment.

[25] McLellan AT, Luborsky L, Woody GE. An improved diagnostic evaluation instrument for substance abuse patients. The Addiction Severity Index. J Nerv Ment Dis (1980) 168:26-33. https://pubmed.ncbi.nlm.nih.gov/7351540

[26] Sheehan DV 1, Lecrubier Y, Sheehan KH et al. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. J Clin Psychiatry, 1998; 59 Suppl 20:22-33;quiz 34-57. https://pubmed.ncbi.nlm.nih.gov/9881538

[27] Cottler LB, Robins LN, Helzer JE: The reliability of the CIDI-SAM: a comprehensive substance abuse interview Br J Addict 1989; 84:801-14. https://pubmed.ncbi.nlm.nih.gov/2758153/

## Evidence-based psychosocial treatment

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

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

- Cognitive behavioural therapy;
- Motivational interviewing;
- Motivational enhancement therapy;
- Contingency management;
- Community reinforcement approach;
- Mutual-help groups (including 12-step groups);
- Therapeutic communities

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

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

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

Community reinforcement approach and mutual-help groups generally belong to long-term treatment strategies that in prisons can be used in therapeutic communities. PWDUD in therapeutic communities in prison stay in a dedicated section of a prison with strict rules where they participate in an intensive daily programme of group work and community meetings aiming at mutual aid and self-help, active participation in community life and gaining life skills and vocational training. Traditional models of long-term residential treatment included strict abstinence and only psychosocial treatment methods whereas modern approaches may involve the use of medications to decrease drug cravings and manage comorbid psychiatric symptoms. Indispensable requirements for therapeutic communities in prison are absolute informed consent of participants, management by licensed specialists for treatment of DUD and professional medical supervision preferably by a psychiatrist.[28]

The selection of treatment techniques offered may depend on the assessment of the severity of the DUD, the pattern of psychoactive drugs consumed and the availability and training of specialized therapists for PWDUD: less severe disorders may sufficiently be treated with short-term interventions whereas severe ones may need long-term treatment; opioid use disorders best are treated with medication assisted treatment whereas stimulant use disorders have been shown to benefit best from contingency management; therapists experienced most with one of the listed techniques may prefer this method whereas others my combine several techniques. Shortage of therapists in relation to patients in need of treatment and considerations of cost efficiency may lead to conduct group treatment rather than individual sessions.

[28] EMDCCA: Therapeutic communities for treating addictions in Europe. Evidence, current practices and future challenges, 2014.
https://www.emcdda.europa.eu/system/files/publications/779/TDXD14015ENN_final_467020.pdf

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

## Evidence-based pharmacological treatment

Evidence-based pharmacotherapy for PWDUD include treatment for symptoms of psychoactive drug withdrawal, maintenance treatment for people with opioid drug use disorders, emergency treatment of overdose intoxication and pharmacological treatment of all mental and physical comorbidities.

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

Standard treatment for withdrawal of opioids is tapering medication of long-acting opioid agonists such as methadone or buprenorphine over at least 2 weeks or tapering doses of alpha-2-adrenergic agonists.

For benzodiazepine and alcohol withdrawal syndromes, close monitoring and long-acting benzodiazepines in tapering doses not longer than two weeks is the standard.

Medication for withdrawal syndromes of stimulants (amphetamine and cocaine), cannabinoids if occurring at all, and the many new psycho-active substances (NPS) are less well defined and limited to symptomatic treatment. Any medical withdrawal management should be accompanied by psychosocial support.

The rapidly increasing number of NPS and their often, ill-defined pharmacologic actions, toxicities and dependency hazards cause considerable problems in identifying, diagnosing and treating users. The most frequently found substances in prisons consist of synthetic cannabinoids, synthetic cathinones, new synthetic opioids and new benzodiazepines[29]. Their in part overlapping action profiles let categorize them as depressants, stimulants or hallucinogens. Psychosocial treatment of DUD with NPS use does not differ from DUD with other psychoactive substances. Treatment of withdrawal from or intoxication with NPS is limited to symptomatic treatment and there is no evidence for any specific medication-assisted treatment. Detailed information can be gathered from the NEPTUNE (Novel Psychoactive Treatment UK Network) Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. [30]

Maintenance treatment for opioid use disorders (OUD) with opioid agonists, earlier on called opioid substitution treatment (OST) and now generally named opioid agonist treatment (OAT), or medication assisted treatment (MAT) of opioids disorders or medication for opioid use disorders (MOUD) plays a major role because it has been proven to be the most effective treatment option of OUD in terms of reduction of mortality, reduction of transmission rates of

[29] EMCDDA: New psychoactive substances in prison. 2018. https://www.emcdda.europa.eu/publications/rapid-communications/nps-in-prison_en

[30] NEPTUNE (Novel Psychoactive Treatment UK Network) Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf

blood-borne infections (HIV, Hepatitis B and C), reduction of rates of criminal re-offending and improvement of social and occupational functioning.

Standard treatment of MOUD is prescribed medication of oral long-acting opioid agonists such as methadone and buprenorphine although also slow-release morphine and even injectable heroin under medical prescription and supervision has been shown to be effective. Methadone and buprenorphine for treatment of OUD have been included in the WHO Model List of Essential Medicines. Start, maintenance and termination of MOUD need close supervision of therapists trained in MOUD to avoid too low doses provoking relapses, to avoid overdoses leading to intoxication and to control for avoidance of diversion and misuse of the medication, particularly in custodial settings. MOUD should be combined with psychosocial treatment as much as possible, however, it has been shown to be effective even without psychosocial support whereas psychosocial treatment of persons with OUD without MOUD has been shown to be less effective. There is ample literature on details and feasibility of MOUD in prisons as listed in C) International standards and principles for people deprived of liberty (PDL) with psychoactive drug use disorders (DUD) in prison.

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

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

An important and potentially life-saving pharmacological intervention is the application of the opioid antagonist naloxone in opioid intoxication. Naloxone injected or nasally applied reverses the effects of opioids on its receptors including the life-threatening respiratory depression in opioid overdosing within minutes. Therefore, also naloxone has been included in the WHO list of essential medicines, it always should be available together with resuscitation equipment in the medical emergency box of each prison. Take-home programmes of naloxone together with the correspondent information and training have been shown to reduce the excessive rate of opioid overdose related deaths in the first days after release of PWDUD from prisons.[31]

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

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

## Continuity of care for PWDUD

DUD, like any other chronic health conditions require continuity of care for optimal treatment outcomes. PWDUD in contact with the criminal justice system face risks of interruptions of

[31] WHO: Preventing overdose deaths in the criminal-justice system. Updated reprint 2014. https://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

treatment and care when undergoing criminal justice measures that considerably can impair their health. Although many PWDUD may undergo care and treatment for their DUD first time when they are imprisoned, others may have been on long term treatment such as MOUD in community facilities and experience interruption of their treatment when arrested in police custody or imprisoned or transferred to institutions where opioid agonist treatment is not available resulting in withdrawal syndrome, loss of opioid tolerance and risk of intoxication. Thus, there is a need for a joined-up approach with civilian services caring for PWDUD and the police detention and criminal justice system to make the continuation of MOUD available for those PWDUD under maintenance treatment.

The preparation of PWDUD for release including cooperation with civilian public services and NGOs caring for PWDUD is of utmost importance for the seamless continuation of care in the most critical phase after release from prison in terms of psychosocial support for housing, occupation and social integration and prevention of re-offending but also of saving lives: the excessive high mortality rate of PWDUD after release considerably can be reduced by proper information on the loss of opioid tolerance in people with OUD, uninterrupted continuation of MOUD after release and naloxone take-home programs. [23, 32]

## Recommendations

*Legal framework*

1. Review penal law in regard of compliance with international recommendations and human rights standards in view of sentencing practices and availability of alternative sanctions for PWDUD;
2. Provide legal provisions for diversion, warnings, mediation, fines, restorative justice and referral to treatment for offenders with DUDs at all levels of the criminal justice system;
3. Establish or strengthen organisational structures and resources for probation services and community sanctions;
4. Advocate sentencing practices for PWDUD offenders to non-custodial measures and avoidance of pre-trial detention whenever possible and provide awareness raising and training of judges in this regard;
5. Consider transitioning authority over prison health care away from penitentiary administrations to specialised services within the Ministry of Justice or the Ministry of Health or other public health authorities;
6. Provide legal provisions and other regulatory framework that allow the internationally recommended harm reduction and treatment measures for PWDUD in prison such as opioid agonist treatment in MOUD and all other interventions as recommended by WHO and UNODC[33]and the expert group on opiate agonist treatment.[34]

[32] Marsden J, Stillwell G, Jones H et al. Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. Addiction (2017), 112:1408-1418
[33] Pont J, Harding TW: Organisation and Management of Health Care in Prison. Guidelines. Council of Europe, 2019. https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69
[34] Guide on the case-law of the European Convention on Human Rights
Prisoners' rights, updated April 2021. https://www.echr.coe.int/Documents/Guide_Prisoners_rights_ENG.pdf

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

*Ethical standards*

8. Ethics in treatment of PWDUD is to be based on the internationally consented principles of healthcare ethics in prison and made known and accepted by the whole prison community;
9. Abolish involvement of health care staff in any custodial and disciplinary punishment measures and abolish any influence of non-medical staff on clinical decisions by healthcare staff;
10. Integrate treatment and harm reduction programs for PWDUD in prison with those available in the community to the greatest possible extent;
11. See for free access of PWDUD to treatment and harm reduction measures equivalent to those available in the community and for females at least equivalent to those for men;
12. See for sufficient staffing or contracting of trained therapists for PWDUD in prisons;
13. Stipulate fully informed consent for treatment of PWDUD and abandon compulsory treatment of PWDUD;
14. Keep medical confidentiality in treatment of PWDUD to the greatest possible extent;
15. Implement a concept that ensures continuity of care after release through information sharing and cooperation with health services, including the availability of take-home naloxone programs upon release from prison to prevent mortality.
16. Consider needs of particularly vulnerable groups among those in treatment such as, people with additional mental disorders, women and juveniles with DUD;
17. Stipulate absolute professional, clinical independence of health care professionals providing treatment for PWDUD;
18. Request high professional competence and continuous training of everybody involved in the treatment and care of PWDUD and support them by developing training curricula and guidelines.

*Treatment services and interventions*

19. Revise and adapt human resources for adequate care and treatment services for PWDUD in the criminal justice system;
20. Revise and adapt premises in prisons for adequate care and treatment of PWDUD;
21. Revise and adapt cooperation/contracts with civilian public and NGO facilities for care and treatment of PWDUD in prison;
22. Review and update continued training and guidelines for all criminal justice personnel involved in decisions on and implementation of treatment and care of PWDUD;

23. Train primary care physicians in screening for and identifying PWDUD upon admission for immediately needed interventions, assessment of risks and comorbidities and referral to specialized services if needed;

24. Consider specialized training and licensing of primary care physicians in prisons on opioid agonist treatment and training for screening of drug use disorders upon admission;

25. Equip and maintain primary health care units with medicines and resuscitation devices for drug related emergencies;

26. For meeting the need for specialized treatment services for PWDUD in prison get an overlook for availability of therapists experienced in current evidence-based standards of treatment of PWDUD within and outside the prison system and the training capacities for future drug therapists in cooperation with civilian public and NGO agencies;

27. Plan structured and cost-efficient operation of specialized psychosocial interventions for short-term and long-term therapies for PWDUD in prison in relation to their availability and patients' needs;

28. Provide the availability and professional pharmaceutical management and control of medication assisted treatment for opioid use disorders, i.e., opioid agonists such as methadone and buprenorphine for the medication assisted treatment of withdrawal syndromes and in the framework of clearly defined opiate agonist maintenance treatment programs in prison undergoing quality control and continuous evaluation;

29. Arrange for specialized care and treatment of psychiatric and physical comorbidities of PWDUD by consultation and referring to the appropriate specialists and specialist facilities;

30. Arrange for continuity of care and treatment of PWDUD by uninterrupted treatment of those who had been under treatment before imprisonment by a joined-up approach with civilian services caring for PWDUD and the police detention and criminal justice system;

31. Arrange for continuity of care and treatment of PWDUD upon release by close cooperation with civilian public or NGO agencies involved in the care of PWDUD and prevention of intoxication related deaths after release by proper information on imprisonment-induced loss of tolerance and uninterrupted continuation of medication for opioid use disorders;

32. Consider implementation of naloxone take-home programs upon release from prison for persons with opioid drug disorders.

# Literature Review of international standards and principles for developing comprehensive treatment systems for people deprived liberty (PDL) with psychoactive drug use disorders (DUD) in prison

For addressing development of *comprehensive* treatment systems for people deprived of liberty (PDL) with psychoactive drug use disorders (DUD) in prison, the author includes as a first part (A) in the literature review the documents containing the standards and principles of providing health care in prison serving as basis also for the treatment of persons with psychoactive drug use disorders. Likewise, in keeping with the principles of equivalence of care, the second part (B) contains documents on international standards and principles for treatment of all people with psychoactive drug use disorders (DUD), some of them contain chapters focusing on treatment in prison. Part C focuses on documents on standards and principles of treatment of people with drug use disorders (PWDUD) in prison.

## A) International standards and principles of providing health care in prison

*Council of Europe*[35]

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

Recommendation CM/Rec (2014) 4 on electronic monitoring

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

Recommendation R (98) 7 concerning the ethical and organisational aspects of health care in prison

Recommendation R (93) 6 concerning prison and criminological aspects of the control of transmissible diseases including AIDS and related health problems in prison

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

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

[35] All of the Council of Europe Recommendations can be found at https://rm.coe.int/compendium-e-2020-final/16809f3927

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

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

*United Nations*

United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment .http://www.cirp.org/library/ethics/UN-medical-ethics/

United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), 2016 https://undocs.org/A/RES/70/175; https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

UNODC, WHO: Good governance of prison health in the 21st century. A policy on the organization of prison health, 2013. https://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

World Health Organisation: Prisons and Health, 2014. https://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

## B) International standards and principles for treatment of people with psychoactive drug use disorders (DUD)

*Council of Europe*

Pompidou Group, Council of Europe: Opioid agonist treatment Guiding principles for legislation and regulations. Council of Europe, 2017 https://www.bing.com/search?q=Opioid+agonist+treatment+Guiding+principles+for+legislation+and+regulations&cvid=e0c6478a509c44b1a5da6767decef496&aqs=edge..69i57.1490j0j1&pglt=299&FORM=ANNTA1&PC=ASTS

*United Nations*

UNODC: Treatnet Quality Standards for Drug Dependence Treatment and Care Services, 2012. https://www.unodc.org/docs/treatment/treatnet_quality_standards.pdf

WHO, UNODC: International Standards for the Treatment of Drug Use Disorders, 2020 https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders

*European Union*

EMCDDA: Health and social responses to drug problems. A European Guide, 2018. https://www.emcdda.europa.eu/system/files/publications/6343/TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf

EMCDDA: Preventing Overdose Deaths, 2018. https://www.emcdda.europa.eu/system/files/publications/2748/POD_Preventing%20overdose%20deaths.pdf

EMDCCA: Therapeutic communities for treating addictions in Europe. Evidence, current practices and future challenges, 2014. https://www.emcdda.europa.eu/system/files/publications/779/TDXD14015ENN_final_467020.pdf

*United Kingdom*

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

*USA*

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

## C) International standards and principles for people deprived of liberty (PDL) with psychoactive drug use disorders (DUD) in prison

*Council of Europe*

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*United Nations*

UNODC (Treatnet): Drug Dependence Treatment: Interventions for Drug Users in Prison https://www.unodc.org/docs/treatment/111_PRISON.pdf

UNODC, WHO: Policy brief. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions, 2013. https://www.unodc.org/documents/hivaids/HIV_comprehensive_package_prison_2013_eBook.pdf

WHO: Prisons and Health, 14 Drug treatment and harm reduction in prisons (Stöver S, Kastelic A), 2014. https://www.euro.who.int/__data/assets/pdf_file/0020/249203/Prisons-and-Health,-14-Drug-treatment-and-harm-reduction-in-prisons.pdf

WHO: Preventing overdose deaths in the criminal-justice system. Updated reprint 2014. https://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

WHO, UNODC: International Standards for the Treatment of Drug Use Disorders, 2020: chapter 5.3 https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders

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European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Guiney C: Health and social responses to drug problems in prisons, 2018. https://www.emcdda.europa.eu/system/files/attachments/10122/EuropeanResponsesGuide2017_BackgroundPaper-Drug-problems-prisons.pdf

EMCDDA: Health and social responses to drug problems. A European Guide, 2018: 4.1 Prisons and the criminal justice system. https://www.emcdda.europa.eu/system/files/publications/6343/TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf

*United Kingdom*

Her Majesty's Prison&Probation Service: Prison Drug Strategy (2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792125/prison-drugs-strategy.pdf

*USA*

NCCH: Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths. NCCH, 2020 https://www.ncchc.org/naloxone-for-the-prevention-of-opioid-overdose-deaths

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Marsden J, Stillwell G, Jones H et al. Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. Addiction (2017), 112:1408-1418