Addressing the role of criminal subculture on access to medication assisted treatment with methadone and buprenorphine in Moldovan prisons

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Summary

Post-Soviet criminal subculture has gained traction as an important factor shaping drug use and addiction treatment throughout Eastern European and Central Asian Prisons (Azbel 2021, 2020, 2019; O'Hara 2021). This report explores the relations between prisoner subculture and the implementation of methadone treatment in Moldovan prisons. While methadone treatment as HIV prevention and addiction treatment has been available in Moldovan prisons for over a decade, uptake remains low. A research team from Yale University carried out 36 in-depth qualitative with people in two prisons near Chisinau to delineate the socio-structural factors that influence people's uptake of methadone treatment. We found that criminal subculture is the major factor driving relations with methadone treatment wherein illegal drug use and methadone use are stratified along the hierarchical boundaries that divide prisoner society. Subutex is injected by the people with the highest status and stimulants are injected by people with the lowest status. Methadone enrollment or continuation is cause for relegation in the prisoner hierarchy equaling a loss of social and material capital. Moreover, informal and formal governing relations of the prison lay the groundwork for these hierarchical divides of drug use. It appears that the formal prison administration relies on the informal governing of the prison – and, by extension, the enforcement of methadone's low status – to fill the gaps in their struggle to provide security and resources within prison. We conclude with a call for professionals intervening in the Moldovan prison space to heed the logics of criminal subculture when implementing methadone treatment. We provide examples of potential implementation strategies.

Background and motivation for the study

HIV incidence and mortality decreased globally yet continue to increase in Eastern Europe and Central Asia (EECA) where the HIV epidemic remains volatile and fueled primarily by opioid injection. Harsh penalties for drug use have concentrated people who inject drugs (PWID) and HIV in prisons. HIV prevalence among prisoners in Moldova is 2.6% (4.3 times greater than in the general population) (Altice, 2016).

A strategy that expands methadone treatment is the most cost-effective tool to reduce HIV incidence in Eastern Europe (Alistar, 2011). Prison is a key setting for expansion: mathematical modelling conducted by Yale University projects that 20% of HIV infections nationally in the region could be averted with within-prison scale-up of methadone maintenance treatment (MMT) (Altice, 2016). But scale up of treatment within prison and after release is hindered by individual and environmental factors that have been under-explored in previous research (Azbel, 2013; Polonsky, 2015). This study, funded by the Council of Europe[1] and the National Institute of Drug Abuse, is an important step to understanding the impact of socio-material factors on the delivery of methadone treatment in Moldova. In turn, the Moldovan case presents a unique and timely opportunity to research and control HIV transmission via the deployment of MMT, with applications globally.

There were 6,429 incarcerated people (including in pre-trial detention centers, SIZO) in Moldova in 2020 in 17 facilities (including four SIZO, 12 prisons, and one prison hospital). In 2016, there was an estimated 1,600 people in prison who were drug dependent.[2] The number officially registered as drug dependent is significantly lower, however. In 2021, this number was 501 (6.5% of the prison population).[3] There are 159 people (2.4% of the population) registered as HIV-positive.[4]

Moldova is one of the few countries worldwide to introduce HIV prevention strategies into prisons, as recommended by the United Nations, including methadone treatment and needle syringe programs. Methadone treatment began as a pilot program

1. The views and opinions expressed in this work are the responsibility of the authors and do not necessarily reflect the official policy of the Council of Europe or the Pompidou Group.
2. Estimarea numărului de consumatori de droguri în penitenciare, Republica Moldova, 2016. http://www.ccm.md/node/2029, Accessed November 15, 2021.
3. Ibid, 2021.
4. Ibid, 2021.

in Moldovan prisons in 2005. During the next 15 years, a total of 525 people took part in the program. After an initial surge in enrollment the decade following 2009 saw stagnation in the number of new clients. Most recently, in 2021 the number of participants jumped from 78 to 99. In 2020 there were only 21 new patients and during the writing of this report (July 1, 2021) there were 95 clients.[5]

A buprenorphine maintenance program is also available in Moldova, including in prisons from May 2019 to August 2020. In August 2020, the buprenorphine program ended because of a deficit of buprenorphine stock in the country. Starting December 2020, buprenorphine is available only in the community.

The number of clients enrolled in methadone treatment remains stagnant and far below recommended levels. Global estimates posit methadone as effective if adequately translated and scaled up (Kim et al., 2014), requiring at least 40% coverage (of people who are opioid dependent) to substantially decrease HIV morbidity and mortality (World Health Organization, 2012). Modeling analyses from Ukraine project that coverage with opioid agonist treatment of half of all people who inject drugs in prisons, with retention in care after release, would avert 20% of new HIV infections nationally over the next 15 years (Altice et al., 2016: 7). We can see, therefore, that methadone treatment is severely under scaled. Only 1.5% of the prison population currently registered for methadone treatment and in 2016 we can estimate that methadone coverage among opioid dependent people in prison was only 5.3%. Given that the numbers of clients have not significantly changed in that time, we can assume that the coverage is similar today.

I directed my research lens at how a long-standing criminal subculture in Moldova shapes the implementation of methadone. Ethnographic studies describe the importance of a prisoner subculture in post-Soviet prisons, where a robust drug economy co-exists with a rigid social hierarchy (Kupatadze, 2014; Symkovych, 2017a, 2017b). but its potential for influencing methadone implementation has not been previously explored in the region, except in Kyrgyzstan. My PhD research in Moldovan prisons, where methadone is also available but under-utilized, has highlighted the influence of a post-Soviet legacy of criminal subculture on the uptake of methadone treatment (Azbel, 2020). A further analysis of this data has pointed to the influence of an illicit opioid market run by the informal prisoner authorities on access to methadone (Slade, 2020). My research team's previous interviews with people in prison after release in Moldova have pointed to the existence of similar informal structures in Moldovan prisons but their influence on methadone access needs to be further explored, particularly within the prison setting itself (Polonsky, 2015; O'Hara 2021).

5. Ministerul justiției administrația națională a penitenciarelor din republica moldova. RAPORT privind activitatea sistemului administrației penitenciare pentru anul, 2020.

Analytical approach

Numerous studies take up the problem of translating methadone treatment in Eastern Europe and Central Asia (Azbel et al., 2016b, Azbel et al., 2018, Azbel et al., 2015, Makarenko et al., 2016, Polonsky et al., 2016a, Azbel et al., 2013a). These studies attempt to understand why, despite an 'unambiguous evidence-base' attesting to the effectiveness of opioid agonist treatment, it continues to be under-utilized. Quantitative and qualitative research, including my own, outline a number of context-based 'barriers' to effective translation primarily linked to attitudes towards treatment underpinned by insufficient knowledge about addiction and motivation to initiate treatment on the part of both prisoners and staff (Boltaev et al., 2013, Boltaev et al., 2012, Subata et al., 2016).

Several quantitative studies administered surveys among prisoners and staff and identified "negative attitudes" toward opioid agonist treatment (Polonsky et al., 2016a, Polonsky et al., 2016b, Polonsky et al., 2015). My previous research delineated the local misunderstandings of methadone treatment. One study, in which I am a co-author, identifies negative attitudes among Ukrainian prison staff and concludes, "In Ukraine, adoption of opioid substitution therapy is more influenced by myths, biases, and ideological prejudices than by existing scientific evidence" (Polonsky et al., 2015). In another study, my co-researchers and I found an example of such a myth among prisoners in Ukraine who considered treatment with methadone to be mutually exclusive with addiction recovery (Polonsky et al., 2016b). In Moldova, my colleagues at Yale University and I found that prisoners accessing methadone were commonly harassed by other prisoners. We concluded that prisoners are opposed to methadone because they are "embedded within a stigmatizing prison culture…[that] endorses negative myths" (Polonsky et al., 2016a: 94). Such studies explain the barriers to effective scale-up as emanating from insufficient knowledge about methadone's benefits, resulting in a lack of motivation on the part of potential patients to initiate treatment (Altice et al., 2016: 18). The underlying assumption in these statements is that the nature of opioid substitution therapy is locally misunderstood and that this lack of understanding contributes to incorrect treatment translation.

In this qualitative study that follows, I coordinated qualitative interviews with people in prison in Moldova to understand how the social environment impacts the implementation of methadone treatment. In doing so, I take a different approach than classic public health studies to the problem of translating methadone treatment into new settings. Rather than treating methadone treatment as something locally misunderstood, I began this research project with an understanding that medical interventions, translated to new places, can become something different. That is, rather than studying the barriers to

methadone's implementation, I left the possibility open that methadone, like its context, can also become something different in new times and places. I find this a much more productive theoretical lens – inspired by the materialist turn in sociology[6] – for understanding why we, as implementers, often struggle with uptake of medical interventions in new settings.

In their report on the function of criminal subculture in Moldovan penal institutions, Gasparyan et al.[7] conclude that the prevalence of prisoner subculture, structured around a top-down hierarchy consisting of people in prison, works to disseminate rules, organize life, and enact violence. This informal systems functions as a result of a lack of security and material goods provided on the side of the formal prison administration. They report on a coordinated effort of extortion from those at the top of the hierarchy and conclude that people in prison experience less security and a poorer prison environment. Importantly, they write, "The subculture is tolerated and actively utilized by staff in maintaining order. It is also reported that staff may benefit from organized extortion of lower caste prisoners".[8]

To understand how criminal subculture impacts engagement with MMT, I engaged with a 'evidence-making intervention' approach, which I developed in relation to MMT in Moldovan prisons (Rhodes & Azbel 2019). This approach looks beyond individual behaviors to investigate how the prison environment shapes the implementation of MMT. It builds on my dissertation, which uses the case study of Moldova to outline how high-risk within-prison opioid injection, situated within a criminal subculture pervasive to post-Soviet countries, acts to undercut the effective implementation of MMT (Azbel, 2020).

This project takes as an 'evidence-making' approach to implementation science as its guiding theoretical framework. While methadone remains the mainstay of a harm reduction approach to preventing HIV within evidence-based literature, its effects locally vary (see Rhodes & Lancaster, 2019 and Rhodes & Azbel, 2019). Accordingly, in the analysis that follows, I harness the *evidence-making intervention* framework (Rhodes & Azbel, 2019) to delineate the ways that the prison drug economy and criminal subculture work to influence what methadone *becomes* within Moldovan prisons

6. Barad, K. (2007). Meeting the universe halfway: Quantum physics and the entanglement of matter and meaning. Duke University Press. Fraser, S., Valentine, K., Ekendahl, M. (2018). Drugs, brains and other subalterns: Public debate and the new materialist politics of addiction. Body & Society, 24, 58–86. Latour, B. (2005). Reassembling the social. An introduction to actor-network-theory. Oxford University Press.
7. Baseline Study into Criminal Subculture in Prisons in the Republic of Moldova
8. Ibid, p. 7.

Methodology

To inform the expansion of methadone treatment in EECA, I carried out a qualitative study of the environmental factors influencing the implementation of methadone treatment within prison and after release in two prison facilities near Chișinău. The aim of these interviews was to describe the individual-environment interactions that shape within-prison utilization of methadone treatment for prisoners with a history of opioid injection. The facilities were chosen based on their security levels (one high security, Prison 9, and one medium security, Prison 4) as well as their proximity to the capital.

Between May and November 2021, I coordinated a research team of two research assistants to carry out in-depth qualitative interviews with prisoners both on and off methadone treatment. In preparation for the interviews, I conducted two trainings with them on qualitative research methods via the videoconferencing tool 'Zoom'. One research assistant worked in Prison 9 and the other in Prison 4. The former research assistant was familiar with prison 9 as she concurrently worked there as a social worker in the therapeutic community located on site. The latter research assistant had previously worked as a psychologist in prisons but had no experience working in Prison 4. We did not know to what extent familiarity with the prison environment would be an asset or a drawback, so we considered these two forms of familiarity to be beneficial for the study because they provided a diversity of experiences on the part of the study personnel.

The research assistants chose locations that were considered relatively 'neutral' in the eyes of the criminal code i.e. they were neither run by the administration nor the informal prisoner authorities. In the case of Prison 4, this was the library. It was simple for the lower castes (who largely make up all methadone patients) to enter this space. In Prison 9, interviews with people in prison whose allegiances were closer to the prison administration were conducted in the medical facility whereas interviews with people whose allegiances were closer to the criminal authorities were conducted in the prisoner living quarters. The office of the head of the sektor (*nachal'nik sektor*) was used for the interviews with the higher castes since this office is directly in their living quarters. This ensured maximum comfort for the study participants.

The sampling strategy was purposive;[9] we wanted to recruit a diverse sample with respect to time spent in prison, status in the prisoner hierarchy, and experience with methadone and drugs. To recruit people in prison into the study, the research

9. An overview of qualitative research methodology for public health researchers, International Journal of Medicine and Public Health, Vol 4, Issue 4, 2014.

assistants used snowball sampling. They began with their network and spoke to people they were familiar with about the study. After undergoing the interviews, participants would refer people from their social circle. There were no limitations to inclusion, but we generally sought to recruit people who have a history of drug use. The inclusion process was iterative such that, if we found that, for example, people of higher social status were missing from our sample, we tried to recruit them upon the next visit to prison.

Upon meeting the participant, research assistants went through consent procedures, explaining the study goal, procedures, and ethical considerations. If the person agreed to participate they signed the consent form and were given a copy.[10] Interviews were recorded using a Tschisen 8GB voice recorder. They were conducted anonymously (each participant was assigned a participant ID) and without the presence of other people in the room. All data remained confidential and were stored and managed using encrypted servers. The interviews lasted, on average, 47 minutes. After completing the interview, the participants were reimbursed with ten USD worth of hygienic supplies and canned goods as well as tea.

10. See Appendix for ethical approval and IRB approval from the Moldovan Ethical Review Board and the Yale IRB, respectively.

Analysis

Upon receiving the interviews files from the research assistants through Yale File Transfer, I forwarded them to the transcription and translation agency in Kyiv, Ukraine, that our team at Yale University had reliably worked with for six years. Using Dedoose (SocioCultural Research Consultants, 2018), the research team (three people) coded 35 interviews (all of which I reviewed; Charmaz, 2006: 46). I opted for coding the Russian language transcripts to stay closer to the original.

The analysis was simultaneous to data generation. After receiving each interview I would first listen to the audio and take notes. I would send notes about interview technique to the research assistants and we met once a week virtually to discuss progress, analyze the received data, and plan future lines of questioning. This allowed us to adjust the topics addressed in the interview topic guide throughout the course of the study. Some central topics were criminal subculture, drug use, methadone treatment, and health. To better understand how the aforementioned topics were intertwined interviewers asked to recall differences between now and then, specific examples, and had interviewees address hypothetical scenarios (e.g. how could this be different?)

To code the interview transcripts, I carried out a "Poststructural Interview Analysis" (Bonham et al., 2015). I used the coding framework as a form of analysis to map the entangled web of relations that set limits on the kinds of methadones and methadone subjects were possible in the Moldovan prison. This coding procedure was comprised of three non-linear and interrelated steps.

First, I looked to precisely *what* was said in interview accounts. These codes simply answer the question, "what things said have been noted?" (Bacchi and Goodwin, 2016: 116). I highlighted excerpts with taken-for-granted, common sense assumptions and assigned codes that summarized them. For example, I produced a code called "reasons for using heroin" that included excerpts with reasons such as "to avoid overdoses," "to relieve men of psychosis," "to prevent withdrawal," "it's purely for the sick," and "to- help the user."

Second, I coded for the normative assumptions that made what was said "sayable" (Foucault, 1991a: 59). In other words, "what meanings need to be in place for particular 'things said' to be intelligible" (Bacchi and Goodwin, 2016: 117)? Continuing with the example above, I identified the intertwined practices. that make these reasons for using opioids legitimate or 'sensible.' I asked, "What discursive practices give rise to a opioid that is "purely for the sick?". A key practice emerging from the data was that of health producing informal prisoner governance. There were several

key relations incorporated within this practice including what I coded as "communal property." This involved the distribution of communally owned heroin to all prisoners. The normative assumption here was that the materials owned and distributed collectively by prisoners to prisoners confer health.

And last, with a view of what "things said" *do*, I traced how these normative implications generate ways to be. Put differently, this form of analysis treats "things said" as productive since it is through the relations within discursive practices that subjects and objects are continually formed" (Bacchi and Goodwin, 2016: 118). As Bacchi and Goodwin emphasize, "hence, they [discursive practices] need to be studied in terms of what they produce, or constitute, rather than in terms of what they 'mean'" (Bacchi and Goodwin, 2016: 118). I examined the effects of privileging health within communal property on what objects and subjects can be and do. I coded for objects and subjects that fell within the confines of communal property vs. objects and subjects that fell outside of it. For example, methadone was excluded from communal distribution practices whereas heroin was included. The subject position that emerged was clear: the physically fit prisoner was someone who received heroin treatment while the ailing prisoner took methadone. In this way, "Poststructural Interview Analysis" allowed me to harness "*what* is said" to examine the processes through which heroin and methadone are differentiated.

Results

Thirty-five people consented to participate in the in-depth qualitative interview: 33 people in prison (17 in Prison 9 and 16 in Prison 4) and two after release. All but two had a history of drug use (See Appendix A for a chart outlining the participant characteristics). Six belonged to the *poriadochnyi* caste, eight identified as *obizhennye*, and the rest were *neputevyi*. Thirteen were currently enrolled in methadone and the rest were not (four, however, had been enrolled previously and discontinued).

While the majority of people we got in contact with were eager to participate and share their experiences anonymously, there was general suspicion about our role in the prison as researchers. We found that the suspicion ran, like many things in the prison, along caste lines. Those higher up in the hierarchy (the poriadochnye) were generally unwilling to talk. For some who did participate, the topic of drug use was off limits (Participant 4_1 did not even want to discuss clean syringes even while there is an official needle syringe program in the prisons because it was too close to the topic of drug use). Ten people in Prison 4 and eight people in Prison 9 did not give consent to participate. Their reasons were as follows: "No one cares about us, especially not Europeans"; "What's the point of talking? I've been here ten years and nothing has changed."; "I'm the one who has to live here and I don't want problems."; "What will I get from this anyway? The hygienic goods aren't enough."; "I'm busy working."; "We don't have any drug users and if we did, we would kill them."; and "I am not allowed to sign anything."; No reason provided.

The Moldovan prison system is overwhelmingly defined by the governing of criminal subculture which, with a longstanding pan-Soviet legacy, adheres to a set of rules, called the criminal code, that structure all aspects of daily life within Moldovan prisons. All prisons in Moldova (to varying extents) are indeed run and controlled by these rules which have undergone a radical transformation since the fall of the Soviet Union.

I will first share general information about how criminal subculture is structured followed by the way that it intertwines with the administration of drugs and methadone treatment.

Relations between formal and informal governing structures: now vs. then

The decisive role that criminal subculture plays in virtually all aspects of lives hinges on the relationship between formal (the prison administration) and informal (the people in prison) governance. As in many post-Soviet countries, the legacy of the informal control of prisons emerges from the inability of the formal administration to provide for basic law mandated resources for prisoners (e.g. food, housing, living space, security). In Prison 4, according to participant 4_7 there are 800 people in prison and four staff on duty at night. This vacuum is filled by the resources provided by criminal authorities; mainly, security.

The interaction between the administration and the *blatnye* is therefore mutually beneficial. Whereas the *blatnye* control the majority of prisoners and enforce discipline and order the administration turns a blind eye to many forbidden activities such as gambling and the possession of cell phones, drugs, alcohol. There are rumors that the *blatnye* also pay off the administration for making these concessions but no information as to how these transactions work. Perhaps this is just speculation on the part of people in prison but, certainly, there speculation is widespread.

Most participants explained that the role of nostalgia for Soviet subculture plays a critical role in the function of power. It provides a narrative motivating the hold that criminal subculture has over prison governance – a higher order ideology. This sentiment was echoed in most participants' accounts. As Participant 9_10 said, "Criminal subculture is not about tradition, it's about corruption." Hearkening back to a Soviet ideal where criminal subculture brought order and morality to the prison, it is now (and unlike in Kyrgyzstan, Azbel 2019), acknowledged by most stakeholders and prisoners that the subculture is about extortion, corruption, and intimidation. As participant 9_2 said, "there's a sense that if your parents got rich (moved to Italy), then you can move in the ranks."

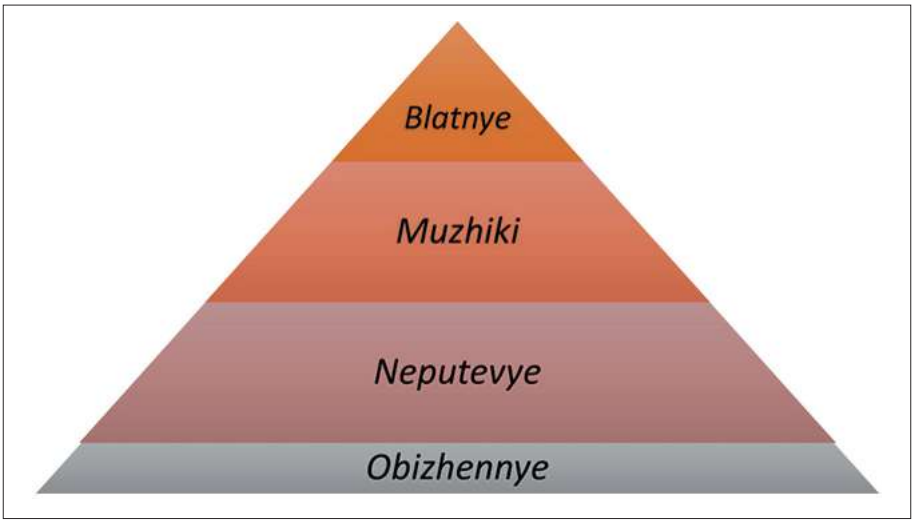
Important, however, and less often acknowledged, is that the prison administration benefits from this system since it is a way for them to maintain control over the prison. As Anastasia, a stakeholder, commented, "There is little political will, since the administration gets major benefits from it." Additionally, the financial connection between organized crime and the government brings benefits that work to further the hold of criminal subculture on prisoner society. This is not to say that staff are financially benefiting from prisoners selling drugs; they are concerned about the consequences for potential corruption. It is, rather, a corruption at higher levels as well as the function of security that criminal subculture plays. This is why the prison administration turns a blind eye to drug acquisition and use within prisons.

While in large part retaining their hold on everyday life (finances, social standing, management of resources, informal rule making, relations with the formal administration, meting out punishment and reward etc), the influence of informal governing structures has waned over the past decade. As Mirlan – an NGO employee – explained, the increase in prisoner violence, increased suspicion to outsiders, and harsher enforcement of informal rules can be attributed to the waning influence of informal governance on prisoner life. The feelings of insecurity that this generated motivated the informal leaders to double down on their control of prisoner life. Their management of prisoners' drug use increased accordingly.

Hierarchical divisions within prisoner society

Life is structured around hierarchical boundaries within prison society. Similar to other post-Soviet criminal justice systems (Azbel, 2020, Piancentini 2015, Kupatadze 2012), one's hierarchical standing is determined by a lifetime of deeds in keeping or in opposition to the criminal code. Once you are demoted in the hierarchy, there is generally no way back. As participant 9_5 notes, "we are a separate government."

Figure 1



Generally, as in other post-Soviet countries (Slade 2018, 2016; Azbel 2020; Azbel 2021; Piancentini 2015), people in prison are divided into two main categories: *poriadochnye* (the 'decent ones,' or the higher casts) and the *ne poriadochnye* (the indecent ones). These two categories are then further divided. The *blatnye* and *muzhiki*, for example, form the *poriadochnye* caste. The *blatnye*, at the top, make governing decisions (they "watch over" the prison) and do not perform work. The *muzhiki*, in high moral standing, perform work and participate in decision-making processes such as governing meetings (*skhodniaki*). The non-*poriadochnye* are the lower castes, or those who have committed an infraction according to the criminal code. These are primarily the *neputevye* (where most methadone patients find themselves) and the *obizhennye* (the untouchables). As participant 9_9, who belongs to the *neputevye*, said, "they (the *neputevye*) don't take on the responsibilities of carrying out the criminal code. I live like a person but I don't have to have those responsibilities or answer for anything." Once you are demoted to the *obizhennye* you remain there for life.

In general, it is not in the interest of the informal leaders (the *blatnye*) to lose *poriadochnye* because this signifies a loss of governing power. Participants note, however, that the number of *neputevye* is increasing. The general distribution between the castes is as follows: 40% *poriadochnye*, 45% *neputevye*, and 15% *obizhennye*. There are also more finely grained distinctions, such as those related to the people who work for the prison administration as well as the *smotriaschie*, members of the *blatnye* who

govern certain resources or aspects of prisoner life like the *obshchak* (the common fund). Additionally there is the *vor*, the leading criminal figurehead of the country and a *polozhenets* (a single person in charge of the prison).

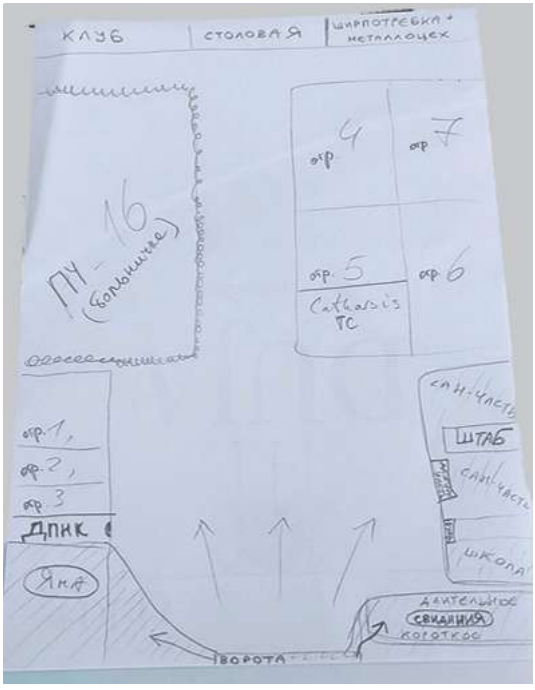
Furthermore, one's caste determines one's access to resources and governing power including living standards and *slovo* (literally, one's word) or, the say that one has in resolving conflicts. That is, in a conflict, if one has lower social standing, their 'word' is less likely to carry weight. As participant 9_9 notes, "being able to answer for your word is very important." Demotion in the hierarchy translates to a diminished possibility of defending and advocating oneself and one's interests, especially in times of insecurity and conflict.

Spatial divisions within prisons

Gavin Slade, Laura Piancentini, and I have done extensive work as to the relevance of space in the prison environment (Piancentini 2015, Azbel 2019, Azbel 2020). The large open spaces with barracks – as opposed to cells – structure life in post-Soviet prisons, creating the conditions for an informal governing of the prisons by the prisoners themselves. Indeed, this is the case for the majority of the prisons in Moldova including the two I did fieldwork in for this paper.

Incarcerated people lived in what is called a *sektsia* or sector. Each sector contains two or three barracks. In each barrack there can be 4 to 60 people depending on one's social standing with the lower capacity designated for the *blatnye*. You can see the barracks labeled 4, 5, 6, and 7 in the sketch of Prison 9 in Figure 2.

Figure 2



One's social standing (and caste, by extension) works to limit their movement within the prison space. This is most prominent in the divisions in living space. Firstly, the *poriadochnye* and *non-poriadochnye* live separately with the former living in superior conditions (more space and resources). The latter are limited on where they can move within the prison space; for example, the *neputevye* can't enter the upper floors which house the *poriadochnye*. The *poriadochnye*, on the other hand, are treated with suspicion when they enter the administrative quarters (the *shtab*) of the prison or the living areas of lower castes. They have to be accompanied by another *poriadochnyi*, who watches them for any potential suspicious activity, when they do need to go to these spaces.

A particularly important division is how much the *poriadochnye* and non *poriadochnye* can interact with each other in certain defined ways. For example, the *muzhiki* and *neputevye* cannot share food. The *obizhennye* cannot shake hands, share cigarettes, or be in the same space as any of the higher castes. They are practically untouchable.

When a conflict arises (i.e. unsettled debt, someone gives someone in, looming physical reprecussions for breaking the criminal code) an incarcerated person may be under threat of violence and seek protection from the prison administration. Upon leaving the *poriadochnye* (called the *obshchaia massa*), they will be isolated in a separate portion of the prison called the *yama* and assigned the criminal code 206 (self-isolation for protection). Unlike the barracks, this is an isolation cell to which other prisoners have no access. These people may receive methadone there.

Another option to isolate is to live in the DPNK (labeled ДПНК in Figure 2) – this is a region of the prison controlled by the administration. This is because it is located across from the administrative building and people who live there can be policed by the prison adminstration – they are in plain sight. Again, this is where methadone clients live. If methadone clients are in debt to the criminal authorities, they go even further and live in isolation cells [*na iame*] along with the *obizhennye*. They cannot leave this area nor can people of higher castes easily access it.

Interestingly, joining the therapeutic community in Prison 9 is equivalent to stepping down from one's role as a *poriadochnyi*. People who enter this community – which is in a separate wing of the prison – are treated as de facto demoted in the hierarchy and no longer beholden to the rules of the criminal subculture. Methadone use functions in largely the same way.

Other drugs

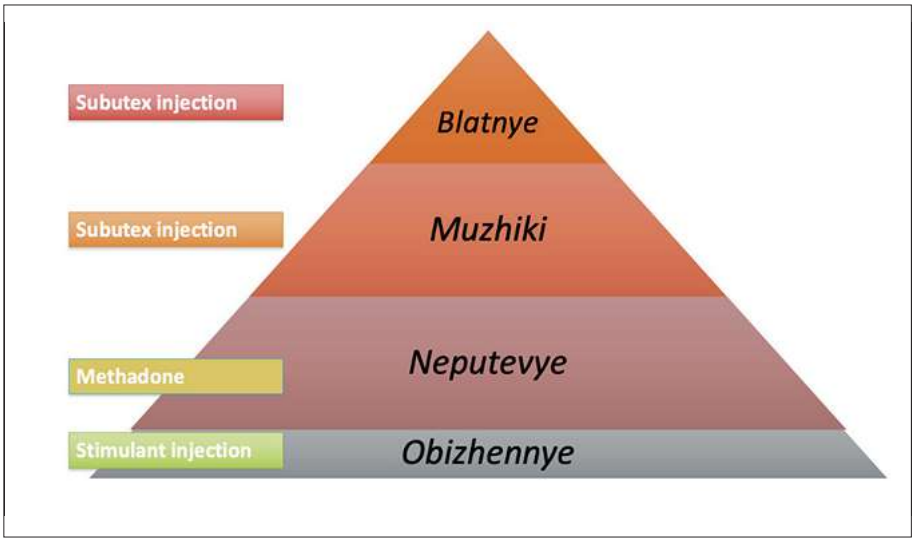
Drugs are readily available in prisons and their distribution and rules of administration are shaped by the criminal code. According to participant 9_10, about half the people in Prison 9 use drugs and 70% of these use opioids (either Buprenorphine [Subutex], methadone, or fentanyl plasters) – an estimate echoed by others. For the *poriadochnye*, Subutex (buprenorphine) is the most common injection drug. A quarter of a pill of subutex costs 800 Moldovan leu (there are about four doses in one pill). Pills of buprenorphine are crushed, dissolved, and injected. Heroin and tramadol are also allowed according to the criminal code. Subutex has the advantage that it is cheaper than heroin so it is most commonly used. As participant 9_10 noted, "people who have used heroin don't really feel Subutex. So they sometimes

use Subutex to get control and calm. It's their first choice simply because there is no heroin, to relieve the paints of imprisonment. They're not even searching for the high, they're just trying not to be nervous. Without taking anything, they'd just be naked."

Importantly, there is a distinction in drug use practices (both which drugs are used, how they are acquired, and how they are used) between hierarchical layers of prison society. Unlike in Kyrgyz prisons, the *blatnye* in Moldova and Ukraine use drugs. This is an important distinction as it signifies, for many, a degradation of the moral code which kept the upper echelons of prisoner society from using drugs. While the *poriadochnye* mainly consume opioids, the non-*poriadochnye* (especially the *obizhennye*) also consume stimulants on which there is an informal ban. There are restrictions on what kind of drugs are allowed according to the criminal code (which applies, primarily, to *poriadochnye*). Only marijuana, barbiturates, ecstasy, Lyrica, benzodiazepines, nonbenzodiazepines, and opioids are allowed (e.g. Subutex, heroin). Uppers such as bath salts (like mephedrone) and *vint* (a homemade amphetamine solution that is usually injected) are banned according to the criminal code. As participant 4_11 noted, "before I used a natural product [opioid drugs], but now I use a substitute for drugs: salts and chemicals." According to participants, stimulants are cheaper, motivate more erratic behavior, produce more severe physical consequences. This means, in turn, that it is primarily the lower castes such as the *neputevye* and *poriadochnye* who use these substances. If a person is caught using stimulants they will be beaten and potentially demoted to a lower caste.

Illegal drugs are usually thrown over the prison fence, depending on the geography of the prison, but sometimes delivered in parcels (including in croissants [participant 4_10]). The latter method is less secure and therefore less common (participant 9_3). The estimates for how many people in the prisons use drugs is very high – around two thirds of people in Prison 4, for example. As participant 9_5 explained, the prison administration allows for large shipments of drugs once a month, including 50 liters of spirits.

Figure 3



Money is generally not exchanged for drugs according to the criminal code; such practice is deemed *samoupravstvo* (or self-governance) which is an infraction of the criminal code and results in beatings. Drugs are, instead, monopolized by the informal authorities who restrict their distribution. They are either distributed according to strict rules in the context of games (mostly card games) or smuggled in through regulated processes. This is accomplished in one of two ways. First, rather than buying drugs from each other, drugs are centrally distributed by the *blatnye* during games (see section e below). A second option is to get drugs "pulled in" (in prison slang) from the outside. You can pull in drugs yourself but you have to first inform the *blatnye*. As participant 9_9 said, "anything you do, you have to answer for it." Or you can use the mechanisms they have in place for pulling in drugs and pay them the cost of the drug and the transport associated with it. Either way, if a *poriadochnyi* arranges to "pull in" drugs they must share 50% with the *obshchak* (the common fund run by the *blatnye*). If they pull in through the *blatnye* they will check what is in the drugs that were thrown over the fence. If they find stimulants there (a banned substance for *poriadochnye*) these will have to be either reported or the *poriadochnyi* can bribe the person who found them to give the green light for their use.

One's access to drugs is tied up with one's level in the hierarchy. If you are a *neputevyi* you are not allowed to pull in drugs yourself. If you pull in drugs through the *blatnye* they will deicde what percentage you leave to them and this is usually much more than 50% (more like nearing 90%). If people are caught pulling in drugs on their own terms there are harsh punishments, including beatings. An *obizhennyi* does not answer to anyone, however, and neither does a prisoner who is living separately from the general mass of prisoners ("*na iame*").

The game: gambling and drug use

Gambling on card games makes up a central part of prisoner life. There is an opportunity to play every day (whether it is a barrack-wide, sector-wide, or prison-wide tournament) and the practices of play are highly regimented and regulated according to the criminal code. Generally, the game is a festive occasion which carries with it elements of romance from a foregone time. A case in point is the commonly reiterated adage: "everyone is equal at the gaming table."

Drugs have intertwined with this tradition in particular ways. Before the game begins the most desirable goods (like food and alcohol) are collected from the prisoners and prepared for the gaming table. People who will join the game are treated to alcohol and drugs. Subutex is provided by the *blatnoi* responsible for distribution to everyone who is interested before starting play. Those who will inject enter a separate room where they are given sterile syringes and a dose of Subutex. Afterwards, they return to the playing table.

If the players have winnings from the game, they have to provide a portion of their winnings to the *obshchak*. But many people end up in debt and are unable to pay. Their debts are recorded and they have until the end of the month (the 28 every month) to repay them. If they do not repay, they face severe consequences. Either someone else can take on their debt and they are beholden to this person and carry

out his requests (personal debt is not a reason for relegation, participant 9_9). Or they get relegated in the hierarchy. Relegation due to unpaid debts to the *obshchak* is one of the most stigmatised circumstances for demotion (it is one of the five sins). A *poriadochnyi* who doesn't repay their debt to the *obshchak* becomes a *neputevyi* who can no longer regain their status (unlike most *neputevye*).

In many accounts, the game is presented as something corrupted and a method of extortion. The way its romantic past is currently used is presented as a tool of manipulation to gather money and resources from prisoners. There are reports of the *blatnye* intentionally recruiting participants so that they can accrue finances into the *obshchak*, especially if they know a prisoner has resources. As participant 9_9 notes, "they will find out who his relatives are, and they will bring him into the game and get him into debt." Unlike in Kyrgyzstan, then, it is possible in the Moldovan prison to initiate someone on drugs. In fact, this is reported to be the intention since this is the only way for many to get their daily dose.

Methadone

Methadone is largely shunned by criminal subculture. Participating in the methadone program has a direct effect one one's social standing. In all prisons throughout Moldova, it is very challenging to retain one's social standing as a *poriadochnyi* while on methadone. In Prison 9, for example, only one person uses methadone officially and retains their status of *poriadochnyi*. This is unlike the functioning of the program in Kyrgyzstan where one can indeed retain their status when they are on methadone. Participant 4_2 recounts, "as they say, that's how it's done there. There are certainly ways there [*postanova*]: either you quit [methadone] and come with us or you keep on taking it and get demoted [*idi na lizhi*]. I couldn't make it without methadone, so I got demoted."

We can see that methadone participation is related to one's social standing. Once someone enters the methadone program they are automatically demoted in the hierarchy; similarly, if they enter the prison on methadone and do not quit the program, they are also demoted. Upon entering the prison for the first time you are informed of this rule and, if you are already on methadone when you come into SIZO, you have two weeks to go off the program. Participant 4_11 is a rare example of someone who went off methadone to retain their status. He says:

> When I got in here some people close to me they told me it's best I quit methadone, because if I stay on I would have a bad life in prison...I stopped right away and this was very hard. I had thoughts about cutting my veins or hanging myself, because it was so hard. So if you're withdrawing from heroin or poppy for two weeks with methadone it's three months. It's terrible.

Unlike in Kyrgyzstan, where the *blatnye* sometimes provide tapering with other substances like heroin for people going off methadone this does not seem to be the case in Moldova. In general, even for those within the methadone program there does not seem to be an option for reducing their dose and going off methadone step by step, let alone for those who are doing so to retain their status in the hierarchy.

Losing one's social standing has severe repercussions for one's life. As I described in Section A above, a demotion results in an inferior living space, restrictions on movement, loss of integrity in resolving conflicts, loss of resources from the *obshchak* as well as other repercussions.

Prison facilities vary in terms of their support for drug use and their relegation of methadone patients to less desirable positions in prison. For example, Prison 4 allows methadone patients to live among the majority of prisoners but, in Prison 9, they live separately. Only one participant lives among the *obshchaia massa* (the *poriadochnye*) and takes methadone in this facility. In order to maintain this status he performs the dirty work (cleaning etc.) in these facilities. This difference between facilities is largely a function of the security level of the prison; because prison 9 is high security it houses people with longer sentences who more strictly adhere to the limits of the criminal code since they have to answer to it for a longer time.

Participants in Prison 4 noted that they are not allowed to work certain jobs given by the prison administration if they are on methadone. Some do work as an exception but this is a barrier to receiving methadone as their shift begins at 8am and methadone distribution begins at 10am. The result is that they lose resources both from the official and unofficial prison administrations.

Methadone is seen as a drug. Clients call themselves and others *narkomany* (druggies), even if they are only taking methadone. Participant 4_11 says, "Methadone is the worst drug, in fact it's all chemicals. It destroys the brain and gets into your bones. It's much worse than heroin." It follows, then, that most participants were seeking to end their methadone treatment. Detoxification with methadone is not an option and participants report difficulties changing their doses. They shared plans of lowering their dose because to do so relieves the body from the stress of methadone. Some, however, stated that they thought the release from following the criminal code was a relief. They preferred their simpler life as a *neputevyi*. When methadone clients decided to quit methadone and began to withdraw they report being provided with sleeping pills or benzodiazepines by the medical staff.

The divisions in space according to hierarchical lines play an important role in the making of methadone. Because methadone is administered in the medical facilities which are in the formal administration run part of the prison (the *shtab*) methadone patients need to cross over into this portion in order to receive this dose. Normally, people in good moral standing with the criminal code are discouraged from going into this portion of the prison. If they do so, they are accompanied by a fellow caste member (see Section A on space above). The interviewer asked participant 9_2 if it was possible to get methadone anonymously and he responded:

> It's not possible! How can you go into the *shtab* without anyone seeing? It's not a mall where you can just disappear. You're walking through the whole territory of the prison, everyone sees…Everyone [from the *poriadochnye*] who goes to the *shtab* has to let others know and has to bring someone with them.

He follows up by making the point that the door is closed behind him when he takes methadone whereas this isn't done when he is getting just regular pills from the doctor and this draws suspicion.

The practices of administration and the way they brought certain people in higher moral standing with the criminal code into spaces of lower moral standing played an important role in methadone's becoming. There was a strong sense in the interviews that methadone distribution was meant to be anonymous but that this was virtually impossible in a space where everything was being watched. Participant 9_2 manages a particularly tricky position because he is the only one who receives methadone and lives among the *poriadochnye*:

> Participant: I noticed that they're really not ok with the fact that the administration gives it out. It doesn't matter if it's doctors or not or UNESCO. It's just still the administration, this is the one thing, you understand?
>
> Interviewer: And if someone else distributed it?
>
> Participant: Who else could it be? Some kind magician will fly in?
>
> Interviewer: It can be delivered each morning by car from a drug dispensary. Once the methadone gets dispensed, the car leaves.
>
> Participant: I don't know, but still the administration has to give the green light. It's still an indispensable link in this chain. It's the cops no matter how you slice it.

Like in the account above, the methods of distribution played an indispensable role in the making of methadone in other participants' accounts.

Confidentiality emerged as an important factor in the distribution practices of methadone. Participant 9_3 explains that the doctors make it clear who's on methadone by inviting everyone at once and other people in prison are able to see who's coming: "This has to be a medical secret. But the doctors, they say 'come at this time.' But I come either before or after so as not to expose myself. I don't go with the big crowd of people. People don't really know I'm on methadone."

There is suspicion about the quality and administration of methadone. Some years ago the methadone concentration changed and there seems to also be a variety of colors that the substance can be. Many participants noted that the varying concentration and color made methadone a substance hard to keep track of, thereby lowering trust. Patients were suspicious of prison staff, saying that the methadone was potentially watered down and had variable effects. The connection between the way methadone looked and the effect it had was an important theme. As 9_3 continues, "I can't understand it, it's like the methadone is diluted…sometime's it's bitter, sometimes it's sweet…and I tell them but they're like, "oh come on!" There used to be a less concentrated methadone that they were distributed a few years back and that methadone could not be injected with other drugs; then they switched distributors in favor of a cheaper, more concentrated one that you can indeed inject. Currently the dose is five times as concentrated as the previous one. This new substance emerges as unreliable in its very make up; It is a substance that was hard to trust or keep track of. Patients often preferred buprenorphine which comes in pills and was therefore enacted as more reliable because it cannot be diluted.

Several participants discussed how methadone patients commonly try to get high while on methadone by taking other drugs. They noted that only Subutex, *shirka*, and heroin cannot be mixed with methadone but that sleeping pills like Dimedrol are an option.

It is important to note that methadone has not always been made this way in Moldovan prisons. Indeed, many participants noted that a few years after methadone was introduced even the *poriadochnye* were on the program. It was only after 2008 that the ban on higher caste members taking methadone was put into effect. Many attributed this change to an increase in corruption within the criminal code. Certainly, whether or not methadone is accepted is heavily dependent on the informal governing system of the particular prison. The drug habits of the *polozhenets*, the *vor* appointed informal head of the prison, largely determine how much understanding there is for drug use and methadone among the prison population. As one participant noted, there is a prison in the south where the *polozhenets* is clean [*sportsmen*] and drug use is not tolerated there.

Other services for people in prison

There are other interventions available for people who use drugs in Moldovan prisons. The Therapeutic Community, Catharsis, offers recovery programs but they are not able to fill the available spaces. This is also largely to do with the ways this Therapeutic Community factors into the criminal subculture. From my report in 2021 on these dynamics, I wrote, "There needs to be a careful consideration for the influence of criminal subculture within the Moldovan prison setting on the functioning of the TC.[11] Similar to the therapeutic community (the Clean Zone) in the Kyrgyz Republic[12] for incarcerated people, joining TC Catharsis is equivalent to a rejection of the criminal subculture and the criminal code which guides life within prisons (the so-called '*poniatia*'). Incarcerated people who may have unsettled conflicts with the informal criminal authorities may seek refuge in the TC, producing the TC as a place where one goes when they want to hide from informal criminal authorities." The therapeutic community is not considered 'worse' than joining methadone treatment. They were long considered to be the same by the criminal authorities. However, no one has ever been demoted in the hierarchy for joining the TC (this is largely because people who join do not go back into the general prison population but are, instead, released). Also, as criminal subculture leaders see the improved lives that people lead when they return to the community after the TC, attitudes towards the program are slowly improving. Nonetheless, it is seen as refuge from a person's problems with the criminal subculture and they are, as a result, labeled "kozy" – "goats" or people who collaborate with the formal administration.

Importantly, visiting programs that speed up early release are not considered a breach of the criminal code – this is a principal that has been decided at the highest echelons of the criminal hierarchy. That is to say, that if a certain program of support (like psychosocial support) is necessary for lessening the sentence, people in prison are allowed to attend. This leaves open the recommendation that such reduction of sentences can be somehow tied either to the TC and/or to methadone.

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11. Polonsky M, Azbel L, Wickersham JA, Marcus R, Doltu S, Grishaev E, Dvoryak S, Altice FL. Accessing methadone within Moldovan prisons: Prejudice and myths amplified by peers. Int J Drug Policy. 2016 Mar;29:91-5.
12. Azbel L, Rozanova J, Michels I, Altice FL, Stövers H. A qualitative assessment of an abstinence-oriented therapeutic community for prisoners with substance use disorders in Kyrgyzstan. Harm Reduct J. 2017 Jul 10;14(1):43.

Fieldwork observations

Unlike in Kyrgyzstan, it was particularly difficult to interview members of the higher castes in Moldova. Most did not even come into the administrative buildings to be interviewed and, when approached, they would decline. One of the NGO stakeholders attributed this fact to the weakening hold of criminal subculture on prison life. Since their power is less stable than in Kyrgyzstan, they have more to lose: violence is more common and the willingness to speak is diminished. This lack of legitimacy was palpable across the board in participants' accounts as they commented that the days where moral values were upheld by the criminal code were long gone.

The formal administration, on the other hand, did not want any extra trouble and was suspicious of the interviewers, especially when they were foreigners. They did not allow local interviewers into the portion of the prison where the *poriadochnye* live [*zhilaya zona*]. This was assumed to be because they need to hold up delicate relations and balances of power with the informal leaders and breaking the status quo by allowing outsiders into this portion of the prison to interview would have raised questions. When I did interviews in the prison I sometimes felt intimidated by the prison administration. I definitely got the message that the less I said the smoother things would go for me. Certainly, the fear of the administration in talking about the criminal subculture (especially the security forces) was ever present. Discussing these issues would amount to admitting that they are not able to do their job: to control the prison.

Conclusions and steps forward

We conclude with an analysis of how within-prison environmental factors, and criminal subculture in particular, influence engagement with methadone treatment both within prison and after release. In particular, we focus on the way that prisoners' social practices (e.g. illegal opioid use, prisoners' hierarchical status) impact access to methadone treatment – a key outcome important for reducing the transmission of HIV. We present an action plan with key programmatic changes that will enable a more culturally sensitive methadone treatment program.

This study explored the ways that criminal subculture within Moldovan prisons influences the use of substances among people in prison, particularly surrounding their use of methadone treatment. We found that the methadone of the global health community translates into Moldovan prisons to become something different than expected within evidence-based research. Rather than a mode of HIV prevention and addiction treatment, methadone delineates low social capital that works to exclude people in prison from the governing structures and social and material resources of the prison (e.g. access to drugs is complicated when people initiate methadone and are demoted in the hierarchy). The way that the methadone program emerges is largely intertwined with the social divides within prison and plays strongly into the antagonism between formal and informal governing power (i.e. the prison administration vs. the informal prisoner government).

Divides between formal and informal governments remain staples of post-Soviet prison life (Kupatadze 2014; Piancentini 2016; Azbel 2020). It comes, then, as no surprise that methadone distribution in particular is so contentious, given that it is a substance, distributed by the formal prison administration, that induces dependency. There is a long history of people in prison who side with the prison administration and divulge secrets about prison life (i.e. where illegal substances are kept etc); methadone users are commonly associated with this caste of prisoners. *Methadone enacts, in effect, a dependency on the formal prison administration*. Space divisions play an important role in the making of methadone. Unlike in the celled prisons of the west, the lack thereof in post-Soviet prisons had enabled a criminal subculture that watches over all aspects of life. The dependency on a substance administered by the prison administration (or 'the cops') in a portion of the prison that is not to be entered by prisoners in high social standing makes methadone an object of suspicion.

The divides between formal and informal governing power of the prison date back to Stalin's Gulag and pervade all aspects of prisoner life (Slade, 2016). Of course, there have been major shifts in the past 30 years since the fall of the Soviet Union, primarily shifting the legitimacy of the informal prisoner leaders and the influence of criminal subculture on prison life. In Kyrgyzstan, for example, the informal leaders

(the *blatnye*) hold much more legitimacy than they do in Moldova. In Kyrgyz prisons methadone, while also seen as a tool of the formal administration's manipulation of the prison populace, does not equate to an automatic demotion within the hierarchy (Azbel 2019). In general, it is more tolerated.

In the Moldovan prison setting, and unlike in Kyrgyz prisons, the lack of legitimacy of the informal leaders manifests, in part, in the close relations between the informal and formal prison governments. These close relations mean that the formal prison administration follows the rules of the informal leaders. Participant 9_9 explains this dynamic using the example of the way that the formal administration bans the use of stimulant narcotics in accordance with the informal code:

> R: Yes. First of all if there's this rule from the informal leaders, the cops [the formal administration], if they know there's a stimulant there in the packages, they would never give it to a prisoner, not for any money. Because if the informal leaders find out about this…you understand? There's a whole mechanism here, they're working together like peas in a pod.

This dynamic speaks to a balance of power between the informal and formal authorities where services are exchanged. It is well known that the prison administration cannot carry out their essential duties in the prison due to a lack of resources and staff; they cannot provide proper living conditions, meals, medical care or safety. They receive these services from the informal leaders and, in exchange, the formal administration heeds their rules regarding drugs.

There is also the important economic factor. The illegal drug market provides income for the informal authorities (and potentially for the formal authorities, given their interconnections). A break in this market with the increase of people on methadone would constitute a loss of governing power for both sides. Participant 9_9 comments on this dynamic:

> I: So, you think the police [the formal prison administration] can influence this situation?
>
> R: Absolutely. Absolutely.
>
> I: Why don't they affect it then?
>
> R: Because they don't want to.
>
> I: They don't want to?
>
> R: Because if they're on methadone, Subutex won't go on sale...
>
> I: And what's in it for them?
>
> R: Because they use more of that Subutex, I don't know how it is on the outside now, but I think only prisons use Subutex more than the free ones, you know what I mean?
>
> I: But what's their interest? That you use Subutex?
>
> R: They buy it for pennies, you know what I mean, and sell it for big bucks. It's about profit.

Many participants' accounts describe these collaborations as examples of the corruption of the informal government wherein they enforce the rules of the 'cops' [the formal prison administration] and, in doing so, are no longer true to the criminal code. Our research points to the ways that drugs play into these dynamics. *We conclude that this waning legitimacy of criminal subculture is reason for methadone's more violent rejection in Moldovan prisons than those of Kyrgyzstan*: without the support of the general prison population for criminal authority, methadone becomes more of a threat to their governing order.

It is important to understand that this imperative to avoid dependency on formal prison governments has a sound logic. This is very common in post-soviet countries in reference to all criminal justice administrative authority figures (not medical staff, however). They know that the probation officers are not literally cops but de facto they are in the sense that they are considered the corrupt hand of the state; as such, 'cops' are often the cause of PWIDs suffering. This is what makes methadone delivery by prison administration or health interventions by probation officers so problematic. As Participant 9_3 noted, "if you can't trust them to protect you in any other sense, why would methadone be different? in fact, it's not. it's used as a tool of control and manipulation by criminal justice forces."

There are, however, ways to mitigate this dependency that lie largely in the distribution practices of methadone treatment. Rather than seeing the way a drug is distributed as secondary to its effects, there has been an important turn in the sociology of implementation science that sets the focus on *how* a substance is implemented to understand what effects it produces (Lancaster 2017, 2018; Rhodes 2020; Rosengarten 2019). A case in point in this study is how methadone is distributed produces it as a legitimate drug (when it is thrown over the fence for personal use) or a toxic substance to avoid (when it is provided officially by the prison administration). In this sense, now that we are equipped with the knowledge about how the current implementation practices of methadone produce it as an object of dependency on the formal prison administration implementers and policymakers need to ask ourselves the question: how can methadone be implemented differently to undo these effects?

Here we provide some ways forward for changing the implementation practices to enact a more health-producing methadone. These guidelines provide a roadmap which may be followed in part as per the discretion of the prison department. We see the following two strategies as critical to increasing the status of methadone treatment uptake, and health outcomes within the Moldovan prison space:

- Hold a dialogue with the informal prison government around methadone treatment implementation and effects. Currently, no such dialogue has been initiated (except for, perhaps, behind the scenes). The commissioning of this study is a commendable first step to bringing the dynamics of prisoner subculture into conversation about methadone delivery but a more direct dialogue about ways forward needs to take place. If the prison administration is unable to carry this out, a third party can be enlisted. My research team's experience in Kyrgyzstan, a country with similar dynamics around methadone engagement in prisons, has shown that engaging both prison administrators and informal leaders of criminal subculture in the discussion can productively lead to

adapting the methadone treatment program to better fit the prisoners' needs (Azbel, 2020). This dialogue would be a first step to negotiating an agreement with the informal leaders on how methadone distribution can function within the prison in ways that account for the needs of both governing authorities. These changes need not be seismic but may entail agreements of how better to distribute treatment (i.e. changes in who distributes methadone).

- Particularly if such a dialogue is not possible, although this may be advisable even if it is, methadone patients need to be provided with protection from the informal prison authorities. This may entail separate living quarters (similar to those of the therapeutic community) but must include living standards, provision of safety, psychosocial support, and access to resources that are in tune with those provided by the resources from the *obshchak*. Additionally, people on methadone can be offered decreased sentences (parole or UDO) or entry into halfway houses. This would also enable a methadone program that was more desirable than the one currently on offer.
- It is widely acknowledged that there are unofficial negotiations behind closed doors about the governing of drugs within prison between the informal and formal authorities. The ban on methadone within criminal subculture can be put on the bargaining table in these unofficial discussions. Indeed, given the political will, there are pressure points available on the informal authorities to reduce their stigmatization of methadone patients.
- It is also important to remember that the alternative to methadone is Subutex which people in higher standing within the hierarchy inject. Indeed, there are other instances in the literature of off label injection of Subutex used to treat withdrawal.[13] This distribution of subutex – which does not produce a strong high even when injected – can be seen as a treatment and, like the heroin maintenance program run in Kyrgyz prisons – can be tolerated as a legitimate alternative to methadone.

Additionally, we hold that the implementation practices, including who, how, where, and when methadone is distributed are determinant of its success. We therefore suggest:

- Re-think the way that methadone is distributed to align it with the informal governing rules of the prison. For example, cease to distribute methadone in the administrative building where people are inevitably exposed when they access treatment, consider the distribution of methadone by non-prison affiliated medical staff coming in from the civil sector.

Other suggestions include

- To provide buprenorphine maintenance treatment given that it is available in the community.
- Distribute methadone at more flexible times so that prisoners can continue to work (currently there are some conflicts in scheduling disabling some prisoners on methadone from working).

13. Otiashvili et al. Why Do the Clients of Georgian Needle Exchange Programmes Inject Buprenorphine? European Addiction Research. 2010

It is important to note that the antagonism between governing powers that methadone treatment plays into cannot be undone without structural changes. There needs to be continued advocacy for creating a system where the wants and needs of all people in prison – whether they are sentenced or working there – are addressed. It is only with changes like decreased sentences for drug-related offenses, decriminalization of drugs and reduction of incarceration as a method for managing drug use that people who use opioids can receive healthcare rather than punishment. Integrating the medical care for prisoners within the Ministry of Health is essential for this endeavor. Secondly, while incarceration continues to be a method for cordoning off people who use drugs from society, the structural conditions within prisons such as staff to prisoner ratio and salaries and benefits would ensure a reduction in the reliance on the informal authorities to govern prisons.

While this roadmap is merely a suggestion, it would benefit from the oversight of the Council of Europe or other independent bodies to assist the prison department in facilitating the aforementioned changes.

This study is ideally suited to provide a multi-level perspective on how prisoners engage with methadone treatment throughout the post-Soviet space where prisons are characterized by similar governing dynamics. As shown in studies in other post-Soviet countries (Azbel 2019, 2020, 2021; Rhodes 2019), methadone treatment becomes a drug of low social capital. Kyrgyzstan, for example, has maintained very low uptake despite methadone treatment existing in prisons since 2008. Lessons from these two countries must be leveraged as methadone treatment is rolled out in Ukrainian prisons – a country that is a far greater contributor to HIV incidence throughout the region. Given the low uptake of methadone treatment in EECA (Altice, 2016) coupled with a pervasive criminal subculture (Kupatadze, 2014; Symkovych 2017a), the proposals in this report can be leveraged to promote intervention effectiveness regionally – a crucial step for turning the tide of the world's fastest growing HIV epidemic.

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Appendix A – Participant pseudonyms and demographics

Pseudonym	ID	Age	Prison facility	Enrolled in methadone	Ethnicity	Caste
Sasha	1_4_1	40	4	да	moldovan	neputevyi
Vitaly	1_4_10	33	4	нет	moldovan	neputevyi (sanitar)
Rostislav	1_4_11	38	4	нет	russian	Poriadochnyi (muzhik)
Semen	1_4_12	42	4	да	moldovan	neputevyi
Sergey	1_4_13	45	4	No, formerly enrolled	moldovan	obizhennyi
Maxim	1_4_14	44	4	нет	moldovan	neputevyi
Andrey	1_4_14	38	4	нет	russian	obizhennyi
Anton	1_4_15	24	4	нет	moldovan	obizhennyi
Vadim	1_4_2	35	4	да	рсский	neputevyi
Samir	1_4_3	31	4	да	moldovan	neputevyi
Konstantin	1_4_4	33	4	да	russian	neputevyi
Vladimir	1_4_5	42	4	да	russian	neputevyi
Lev	1_4_6	35	4	да	moldovan	neputevyi
Fyodor	1_4_7	37	4	нет	moldovan	neputevyi (former smotriashchii)
Marian	1_4_8	41	4	No, formally enrolled	moldovan	neputevyi
Marius	1_4_9	46	4	да	moldovan	neputevyi
Daniel	1_9_1	40	9	No, formally enrolled	russian	neputevyi
Mihai	1_9_10	40	9	No, formally enrolled	russian	poriadochnyi
Ionut	1_9_11	38	9	нет	roma	neputevyi (former poriadochnyi)
Ali	1_9_13	42	9	нет	moldovan	neputevyi
Alexandru	1_9_14	37	9	нет	moldovan	obizhennyi
Adrian	1_9_15	34	9	нет	moldovan	obizhennyi
Efim	1_9_16	68	9	нет	russian	obizhennyi
Mikhail	1_9_17	52	9	нет	russian	obizhennyi
Dima	1_9_18	47	9	нет	moldovan	obizhennyi
Nikita	1_9_2	40	9	да	moldovan	neputevyi

Stanislav	1_9_3	38	9	да	moldovan	neputevyi
Viktor	1_9_4	27	9	да	moldovan	neputevyi
Ion	1_9_5	29	9	да	russian	neputevyi
Nicu	1_9_6	37	9	да	moldovan	neputevyi
Viorel	1_9_7	40	9	нет	russian	poriadochnyi
Denis	1_9_8	45	9	нет	russian	poriadochnyi
Rustam	1_9_9	48	9	нет	moldovan	neputevyi
Iura	3_9_1	37	9	нет	moldovan	poriadochnyi
Marcel	3_9_2 (used to be 1_9_12)	37	9	нет	moldovan	poriadochnyi

Appendix B – Interview guide for people in prison

In line with the qualitative interview approach, the Guide is a flexible tool to direct the conversation with the participants and to elicit their stories regarding the key domains listed below. The interviewers will be using "active listening" techniques and will have discretion to decide the order in which they may bring up domains, ask questions, and use further probes during the interview with each participant, to gather the richest data possible. The interviewers may also use additional questions and/or probes not listed in the Guide if the participant brings up relevant issues that may be worthwhile to explore further.

Preamble - Purpose: Establishing initial rapport

Meet and greet the participant, ask how they are doing, refer back to the interview process they experienced in the first interview, and reinforce that, as with the first interview, their story will be valued and will be taken seriously and with respect.

"It is very good to see you again. Just to recap what I had said when we first met, we are hoping to learn more about what people who have served their sentence in Moldova think about addiction, methadone maintenance therapy, and HIV risk, and the experiences they had with these issues. We would also like to know what you think about how and why some people may start drug injection or methadone treatment in prison, about the attitudes of other people in prison towards such prisoners, and about support for people living with substance use disorder in prison and in the community. Your input will be very helpful in designing a program for PWID to encourage the use of harm reduction services, improve their quality of life, reduce stigma and social isolation, and reduce the HIV risk."

"I'll be asking some questions and recording our conversation. I am eager to hear and to learn from you and your experiences. Some questions may be similar to what we discussed last time; I ask them again because we would like to know your thoughts about these issues now that you are living in the community. I am not here to look for right or wrong, and it is your opinion that is of value. We may be asking you some questions that may appear sensitive to you. In situations where this may seem uncomfortable, there are a number of ways in which you may respond. This may include speaking abstractly about events or activities that may be related to others and perhaps not to yourself, as well as making sure that you do not provide a full name that might completely identify another prisoner and/or staff member. If there is a question you do not wish to answer please kindly advise, however I ask you to be as open as you can and say what you think. Everything you share today will be kept confidential and only used in anonymized form for research purposes; it will not be shared with the prison department or other prisoners. We don't have to

report any illegal activities, like drug use and sharing. If you mention any identifying information, it will be deleted from the interview recording. How does this sound? Do you have any questions before we begin?"

Clarify any questions that may arise.

"I am going to start the recording now."

Start recording.

I. Introduction and reentry challenges

1. "I would like to start by asking you a few questions about your life before your incarceration. Think about the month before your incarceration."

   Probes:

   - "What was a typical day like? What were you doing with your time?"
   - "Where did you live? Who were you interacting with?"
   - "Who were the people who supported you? What kind of support did they provide (for example, financial, emotional…)?"
   - "What kinds of things were you concerned about?"

2. "Tell me about your life since you were incarcerated."

   Probes:

   - "Have you noticed any changes in your health since you were incarcerated?
   - How has your health changed?"

3. "Do you feel that you are able to get medical care whenever you need it now?"

   Probes:

   - "Tell me about the kinds of medical care you received in prison."
   - "If no, what prevents you from getting the medical care you need?"

4. What do you feel will be the biggest challenge when you are released from prison?

   Probes:

   - How will you handle this challenge?
   - How easy will it be for you to get medical care/find employment/housing/reestablish relationships?

II. HIV Treatment & Disclosure

5. "When is the last time you got an HIV test?"

   Probes:

   - "Did you get your result?"
   - "Do you feel comfortable telling me about the results?"

6. "Who have you talked to about your HIV diagnosis?"

   Probes:

   - "Is there someone who you would like to tell about your status but have not told?"
   - "If yes, what is stopping you from telling them?"

7. "Have you ever taken HIV medicine (ART)? Are you taking it now?"

   Probes:

   - "If no, what has kept you from getting HIV medicine (ART)?"

III. Within-prison drug use

8. "If somebody in prison craved drugs, what were their options?"

   Probes:

   - "Could they obtain drugs? Which drugs?"
   - "How do they go about it?"
   - "What if they have no/little money?"
   - "What would motivate prisoners to initiate injection drugs in prison?"

9. "Describe the process of razgon (the free giveaway of liquid heroin in prison)."

   Probes:

   - "Can you describe the process from beginning to end: from mixing the solution to injection."
   - "What are the rules from taking from the obschak? Who can and who can't?"
   - "When is the obschak open? What are some reasons the obschak might be closed?"
   - "What do people do when the obschak is closed to get drugs?"
   - "What is the difference between injecting from the obschak or outside of the obschak in prison?"

10. "Describe a situation in prison where you experienced withdrawal or felt the urge to use drugs."

    Probes:

    - "What did you do when you experienced cravings in prisons?"
    - "Has there ever been a time when you wanted to use drugs in prison but you couldn't? What happened?"

11. "Tell me about the last time that you injected in prison."

    Probes:

    - "Tell me about the whole process: How do you get the drugs? The syringe? How do you find a private place to take them?"
    - "How did you decide who to shoot up with?"
    - "How was this different from taking drugs in the community?"

12. "Tell me about the kinds of needles you used to inject in prison."

    Probes:

    - "When you inject, about how many people use the same needle before or after you injected?"
    - "What concerns (if any) do you have about sharing needles? What do you do about that?"
    - "Do you ever try to clean the needle before you inject? How? Do you think it's important to do that?"
    - "Where do you think its more common to for several people to use the same needle, in prison or SIZO? In prison or in the community? Why?"

13. "Do you ever use NSPs in prison?"

    Probes:

    - "Do you know anyone who does?"
    - "Do other prisoners know who is using NSPs?"
    - "Where they treated differently by other prisoners? By staff members?"
    - "What reasons may a prisoner have for abstaining from using NSPs?"

14. "Did you ever have to hide your drug use in prison?"

    Probes:

    - "Whom did you hide it from?"
    - "Why did you have to hide it?"
    - "How did you hide this?"
    - "What are some reasons someone would want to register as a drug user? Why would someone not want to?"

IV. Experiences with drug treatment

15. "What should opioid dependent people do for their addiction in prison? What about after release?"

    Probes:

    - "Should they get medical treatment? If so, what kind?"
    - "When should methadone treatment be an option for someone?"
    - "What are the reasons that someone may agree (or disagree) to take methadone in prison? After release?"

16. "Are you on the methadone program? Were you on it before?"

    If no:

    - "What has to change for you to continue/start methadone?"
    - "How long were you on it before and why did you stop?"

    If participated in prison:

    - "Was it safe to take methadone in prison?"

- "Did other prisoners know you were taking methadone?"
- "Did they treat you differently after you started taking methadone?"

17. "Do you wish to continue/start methadone after release? Did you end up continuing it/starting it?"

    Probes:

    - "How easy or difficult will it be to start methadone after release?"
    - "What is different between taking methadone in prison and in the community?"

18. "Tell me about your life before you started taking methadone. Now tell me about your life after you started taking methadone."

    Probes:

    - "Do you let some people know you take methadone? How do you go about it?"
    - "Do you have anyone in your life who thinks you should not take methadone? Why?"
    - "How easy would it be to increase your methadone dose if you needed to? Decrease? How would you feel if you could increase your dose? Decrease it?"

19. "Do you know anyone in prison on the methadone program?"

    Probes:

    - "Do other prisoners know they were on methadone?"
    - "How are they treated by prison staff? By other prisoners?"
    - "Was anyone ever aggressive or violent towards them? Can you tell me what happened?"

    If yes:

    - "Is there a type of prisoner that may not be bullied for being on methadone? What are they like?"

20. "Do you know anything about the division of prisoners into groups/castes?"

    Probes:

    - "How is it decided who will pertain to what caste? What could possible reasons be for moving between castes?"
    - "Are there certain castes that cannot use NSP or methadone?"
    - "What caste would the people from your group pertain to?"

21. "What are some reasons a person on methadone may continue using other drugs?"

    Probes:

    - "What is the difference between methadone patients who continue using drugs and those who don't?"
    - "What would need to happen for them to stop using other drugs?"

"Thank you very much for your time. Are there any questions you would like to ask of me at this point?"

Topic guide for prisoners, later iteration

RELEASE

- How did prison prepare you
- Met expectations after release?
- Current problems, esp. police

METHADONE

- Where easier to take it?
- How was it decided it was wrong in prison? Who decides and why?
- Starting in prison vs. community. What if coming in already on MT?
- How to get people to switch from razgon to MT? Or vice versa?
- What if demoted in caste, start MT then?
- Place and process of delivery make a difference? 'bolnichka sviatoe mesto'
- Did progon happen? Consequences?

OBSCHAK & JUSTICE

- Novyi avtoritet: what makes him an avtoritet? What's relationship to him?
- Shmon warning. How does obschak know there will be shmon? They let prisoners know? What do they hide?
- Как вольные понятия отличаются от внутриных понятий? Who What are the poniatia? Why are they necessary? Who makes them? Have they changed? How learn them? In all prisons?
- Someone coming in for the first time, how do they determine that they're a certain caste. как отличается усиленный режим от особого и строгого?
- Example of a good act and a bad act? Why wrong?
- How is it decided if поступок is wrong? Who interprets rules? How does someone confess?
- How is it decided who gets into obshchak?
- Conflict: How are conflicts resolved? Who has the final say?
- Punishments: which? How demoted?
- Exceptions: What if they didn't know what they were doing when they did the wrong thing? What if there is no evidence?
- How does the skhodniak work? What is the process like? Describe beginning to end.
- How does progon work? How find out about it?

WORK AND RAZGON

- What's changed since new vor? Work? Castes? Razgon?
- Was the razgon free during the time of the bazaar?
- Why was the bazaar closed?

- Is working mandatory now? Is working mandatory now? Do reds work for obschak?
- Which work done and by whom?
- What you get in return? does every job get razgon? MT patients?
- Sharing? How bring pol'za to obschak?
- What do you get for making shirpotreb? Money? Or heroin? What do gady and obizhennye get for working for the obschak?
- Do they have the option of working for the administrtation instead? Is that more lucrative?
- So there is a magazin? Who is it run by?
- Kto esche stoit na tachkovke?
- What can heroin be exchanged for?
- What do менты get for bringing heroin into prison for obschak?

PONIATIA AFTER RELEASE

- Still exists? How?
- How works in MT program?

MISC

- How was interview in prison?
- How other people see us
- What is health?
- Everything depends on yourself. Где больше все от тебя зависит?

Appendix C – Ethical approval

MINISTERUL SĂNĂTĂȚII, MUNCII ȘI PROTECȚIEI SOCIALE AL REPUBLICII MOLDOVA
Ministry of Health, Labor and Social Protection of the Republic of Moldova

Comitetul Național de Expertiză Etică a Studiului Clinic
National Committee for Ethical Expertise of Clinical Trial

Adresa: MD 2009, mun.Chișinău, str.A.Cosmescu,3 Tel: +373 22 20 54 14; fax: + 373 22 72 30 00; e-mail: comitetetica@msmps.gov.md

Date 28.05.2021, Nr. 1100

At the meeting on 28.05.2021 the National Committee for Ethical Expertise of Clinical Trial examined the documents to the following study: „Addressing the role of criminal subculture on access to opioid addiction treatment in Moldovan prisons"

Sponsor: Yale University School of Medicine, Pompidou Group

Evaluation team: Svetlana Doltu, Frederick L. Altice, Lyuba Azbel, Orsolya Ganesos, Robert Teltzrow, Irina Barbiros, Vladislav Busmachiu

Responsible institution: NGO "AFI"

Analyzed documents:

- Application
- Investigator's CV
- NGO "AFI" agreement
- Agreement of the National Administration of Penitentiaries
- Protocol
- Qualitative interview guidance
- Informed Consent Form

THE FAVORABLE OPINION AND CONFIRMATION OF THE ETHICS STANDARDS IN THE PROPOSED STUDY WERE FOUND.

President of the NCEECT
of the Republic of Moldova
NCEECT/1100/28.05.2021

Prof. Sergiu Matcovschi

Release date: _____

Criminal subculture has gained traction as an important factor shaping drug use and addiction treatment throughout Eastern European and Central Asian prisons. This report commissioned by the Pompidou Group of the Council of Europe explores the impact of prisoner subculture on the implementation of methadone treatment – an evidence-based treatment for opioid use disorder – in Moldovan prisons where it has been available for over 15 years but uptake remains low. A research team from Yale University School of Medicine conducted a qualitative study in two prisons near Chisinau to explore how criminal subculture affects the way that people interact with methadone treatment. They conclude that methadone delivery gets tied up with the power struggles of the informal criminal subculture and the formal prison administration where methadone is equated with the values of the latter thereby repelling the former. Those who enroll in methadone treatment lose their standing in the hierarchy which equates to a loss of social and material worth. The report suggests implementation strategies – primarily ways to distance methadone treatment from the formal prison administration – to improve its appeal, uptake, and treatment outcomes.

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The Council of Europe is the continent's leading human rights organisation. It comprises 46 member states, including all members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

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