Guidance paper on developing strategies for raising standards on drug treatment in the criminal justice system

Council of Europe International Co-operation Group on Drugs and Addictions

POMPIDOU GROUP

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Contents

Acronyms

DUD	Drug use disorders
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
MAT	Medication-assisted treatment
NGO	Non-governmental organisation
OAT	Opioid agonist treatment
PDL	People deprived of liberty
PHC	Primary healthcare
PWDUD	People with drug use disorders
PWOUD	People with opioid use disorder
SEE	South-East Europe
TC	Therapeutic community
ToT	Training of trainers
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Background

The activity "Developing comprehensive drug treatment systems in prisons" was adopted in June 2020 on the initiative of the Permanent Correspondents from South-East Europe (SEE)[1] to the Pompidou Group, the Council of Europe International Co-operation Group on Drugs and Addictions. As part of this activity, a working group was set up, composed of nominated national experts directly involved in the design, implementation and evaluation of drug policies and/or concrete drug treatment programmes in custodial settings. The task of the working group was to elaborate a guidance document on raising standards on drug treatment in prisons and present practice examples, taking into consideration the fact that several international standards and obligations are already being implemented to some extent in all countries of the region. This paper serves the wider aim of this Pompidou Group activity to provide assistance to SEE countries in developing programmes and strategies for the treatment and rehabilitation of detained people with substance use disorders.

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The work of the group was guided by an independent expert[2] commissioned by the Pompidou Group. The document "Standards for treatment of people with drug use disorders in custodial settings",[3] based on current international evidence and recommendations and edited by the Pompidou Group in 2021, serves as a backbone to this guidance paper.

As a result of these activities the working group presents the following strategic guidance for raising standards on treatment of people with drug use disorders (PWDUD) in the criminal justice system.

1. Pompidou Group member states in the South-East Europe Co-operation network are: Bosnia and Herzegovina, Croatia, Cyprus, Greece, Hungary, Montenegro, North Macedonia, Romania, Serbia, Slovenia and Turkey.
2. Jörg Pont, MD, Vienna, Austria. Consultant in prison healthcare. Former prison physician, former medical advisor to the Austrian Federal Ministry of Justice and retired Professor of Medicine at the Medical University of Vienna.
3. Pompidou Group (2021), "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)", available at https://rm.coe.int/2021-ppg-see-prison-2-treatment-standards-background-paper-final/1680a88103, accessed 4 November 2022.

Introduction

Based on scientific evidence and in line with international recommendations and standards,[4] comprehensive treatment of people with drug use disorders (PWDUD) in criminal justice systems needs to build on four cornerstones.

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

In keeping with international standards, background policies for developing standards of treatment of PWDUD in the criminal justice system should include:

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

These principles underline 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 rather than criminal behaviour and taking into account the individual and public health implications of DUD if not properly addressed. In addition, treatment of PWDUD, be it in the criminal justice system or in the community, has been shown to be highly cost-efficient from a public budget perspective.

In the context of this document, drugs comprise all psychoactive substances, particularly those that lead to harmful patterns of drug use and drug dependency. The term DUD comprises the two clinically defined health conditions "harmful pattern of drug use" and "drug dependence".[5]

Treatment of PWDUD comprises psychosocial therapy and pharmacological therapy.

In line with the international recommendation for developing non-custodial measures for offenders with DUD whenever possible, this paper addresses strategies not only for treatment of already imprisoned PWDUD but for all PWDUD in contact with criminal justice systems.

4. An overview of relevant standards and international recommendations can be found in the Pompidou Group background document cited in the previous footnote.
5. WHO/UNODC (2020), *International standards for the treatment of drug use disorders*, available at www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders, accessed 4 November 2022.

Methodology

The needs, intentions and experiences of SEE countries with regard to treatment of PWDUD in criminal justice systems were compiled at the meetings of the working group of nominated experts from SEE to the Pompidou Group and accompanied by a structured questionnaire. The pattern and extent of treatment services for PWDUD in criminal justice systems in SEE countries vary widely due to the states' heterogenous history, culture, economy, legislation and penitentiary system healthcare governance.[6] However, they all have in common a high prevalence of PWDUD in criminal justice systems, with concomitant implications for individual and public health, and existing gaps between treatment options for PWDUD in the community and in the criminal justice system – which need to be filled in keeping with the principle of equivalence of care.

The spectrum of vocational and professional background of the nominated experts to the Pompidou Group, all of them practically engaged in the care of persons and PWDUD in the criminal justice system, ranges from healthcare professionals, mental health experts, education/probation specialists, to prison administration representatives and policy makers from responsible ministries. This spectrum of backgrounds is an asset given the need for a multidisciplinary approach in raising standards on treatment of PWDUD in criminal justice systems.

In order to adapt the international recommendations as much as possible to the needs of the participating countries and the feasibility of implementation, the recommendations covered in this guidance paper have been narrowed down to those prioritised by the representatives of the member states in two working group meetings and further itemised by their responses to a questionnaire. As a result, the focus was laid on improving implementation of the following recommendations.

1. Review and update continued training and guidelines for all criminal justice personnel involved in decisions on and implementation of treatment and care of PWDUD.
2. Consider specialised training and licensing of primary care physicians in prisons on opioid agonist treatment (OAT) and training for screening of DUD upon admission.
3. Ensure continuity of care following release through information sharing and co-operation with health services, including the availability of take-home naloxone programmes upon release from prison to reduce the risk of death.
4. Review penal law with regard to compliance with international recommendations and human rights standards in view of sentencing practices and availability of alternative sanctions for PWDUD.
5. Consider transitioning authority over prison healthcare away from penitentiary administrations to specialised services within the ministry of justice or the ministry of health or other public health authorities.

In addition, a recommendation regarded as a top priority by some countries but not prioritised by the working group was taken into consideration.

6. Provide treatment opportunities for PWDUD who consume substances other than opioids or choose not to take medication-assisted treatment (MAT) while incarcerated, in particular by implementing prison-based therapeutic communities (TCs) or closed TCs outside prisons.

6. Stöver, H. and Teltzrow, R. (eds) (2017), *Drug treatment systems in prisons in Eastern and South-East Europe*, Pompidou Group, Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/drug-treatment-systems-in-prisons-in-eastern-and-south-east-europe/168075b999, accessed 4 November 2022.

Strategies

In the following sections, strategies for implementing the six selected recommendations are elaborated one by one, based on the contributions of the participating country representatives. In the course of the working group's activities, it became clear that for the realisation of all the recommendations, in addition to the provision of indispensable human and material resources, much can be achieved by raising awareness, training, improving inter-professional, inter-institutional and inter-ministerial co-operation, and developing and building on existing resources. Important steps have already been reported in some places in the region as reported by the participating countries regarding: establishing structured drug treatment programmes, OAT and TCs in prison; replacing part of the incarceration period by treatment in closed community TCs; and introducing structured programmes for continuation of treatment and care upon release in close collaboration between penitentiary administrations, national addiction centres, non-governmental organisations (NGOs) and community mental health services. The responses to the questionnaire by the nominated experts from Croatia, Cyprus, Greece, Hungary, Montenegro, North Macedonia, Romania, Serbia and Slovenia have been much appreciated.

Implementation strategies may thus include the following.

- Analysis of context of policy and practice: What is already there?
- Problem analysis: What is missing, what barriers exist, what preconditions exist for achieving the desired result, what are the related costs and risks?
- Stakeholder analysis: Who are the important actors, decision makers, key institutions, main supporters, opponents, main beneficiaries? What are their roles and interests?
- Partnership: What opportunities for partnerships between stakeholders and various services exist?
- Processes and timeline: Prioritisation of key steps? What immediate actions can be taken within existing frameworks? What requires long-term commitment?

Possible strategies for operationalising the prioritised recommendations and thus improving implementation of the relevant standards on treatment of PWDUD in the criminal justice system are presented through three steps: assessment of existing framework, activities to address shortcomings and indicators for tracking progress/achievement of implementation.

The steps proposed below are non-exhaustive and aim to provide ideas for overcoming barriers and achieving progress in improving the implementation of international standards related to the treatment of PWDUD in the criminal justice system. They are formulated from the point of view and role of the main target audience of this guidance paper: policy makers, representatives of national prison administrations directly involved in the design, implementation and evaluation of programmes and policies related to drug treatment and rehabilitation in the criminal justice system, and professionals (social and healthcare staff, law enforcement, court staff, etc.) working with detained PWDUD. Additionally, this paper hopes to serve as guidance and inspiration for decision makers in improving the right to health of PWDUD, in compliance with international human rights standards.

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

According to international standards, appropriate treatment of PWDUD in criminal justice settings requires continuously nurtured professional competence on the part of all those involved in legal decisions on PWDUD and all those involved in their care.[7] This implies that not only healthcare staff but everyone responsible for persons in the criminal justice system, including police, prosecutors, courts, judges, prison administrations as well as custodial and probation staff, needs to understand the nature of DUD as health disorders based on physiological brain alterations rather than a lack of willpower or weakness of character, or as criminal behaviour. They should be made aware that incarceration of PWDUD imposes additional individual health risks and health risks to the prison communities and the community at large.

Professional training and support for achieving this understanding is indispensable for the set-up of standards of harm reduction measures and drug treatment systems within the criminal justice system. Many prisons are not sufficiently staffed with appropriate professional profiles and competencies, so support should be sought by contracting community services and NGOs experienced in the treatment and care of PWDUD. However, custodial staff should also, in their initial and continuous training, be taught about the basics of current concepts regarding DUD, harm reduction and treatment in order to understand these concepts and support appropriately PWDUD. Development of training curricula for the various professional profiles and guidelines should support raising the professional competence on DUD.

Assessment of current training activities on DUD for penitentiary staff: assign to a national expert experienced in PWDUD in prisons the task of assessing the following

- What kind of training activities exist? (e.g. baseline training, on-the-job training) Are DUD included in the training curricula?
- Do training curricula on DUD comply with current and evidence-based knowledge and practice in treatment of PWDUD?[8]
- Are the current trainers qualified for training on DUD or is further training of trainers (ToT) on DUD needed? Are additional trainers needed?
- Are the effectiveness and sustainability of trainings evaluated?
- Is there a sufficient level of knowledge among penitentiary healthcare staff (e.g. primary care professionals, psychiatrists, psychologists, drug therapists), prison staff and social workers on DUD and treatment of PWDUD?
- Is there a sufficient level of knowledge among police officers, prosecutors, judges and probation officers on DUD and treatment of PWDUD and on the individual and public health risk of incarcerating PWDUD?
- Do courts have an expert on DUD available who could support them in their decisions on offenders with DUD?

Activities to overcome deficiencies identified by the above assessment

- Inform and motivate responsible stakeholders (e.g. penitentiary training centres; prison academies; police academies; ministries of justice, public order, health and interior; the medical and juridical faculties of universities; professional boards and academies; training schools/academies for judges and legal professionals) on the need for awareness raising on state-of-the-art knowledge on DUD and treatment of PWDUD. In addition to training courses, interdisciplinary workshops could achieve these goals.
- Advise courts to appoint an expert on DUD who can support the courts in their decisions on offenders with DUD.
- Identify which institutions in the country or international bodies would be able and willing to support the various training activities by providing or designing up-to-date training curricula adapted to the needs of the various beneficiaries and/or provide trainers. ToT for the beneficiaries followed by cascade trainings have been shown to be advantageous in terms of boosting the credibility of trainers (peer effect), while the qualifications and effectiveness of newly trained trainers can be assessed by simulation trainings upon completion of ToT.

7. The peculiarities of treatment of PWDUD within the criminal justice system are highlighted in Section 5.3 of the WHO/UNODC Standards.
8. See list of reference documents in the Pompidou Group standards for treatment of PWDUD in custodial settings.

- Depending on the priorities of the beneficiaries (penitentiary institutions, professional profiles) and feasibility, consider piloting training activities in selected settings and rolling them out more broadly thereafter.
- Use, as much as possible, the existing resources (premises and personnel) of national training centres and structures and adapt and update existing national and international training material.[9]
- Corroborate and sustain training activities by updating associated guidelines and standard operating procedures.

Indicators for achievement of the recommendation

- State-of-the-art training curricula for penitentiary non-medical and medical staff.
- State-of-the-art training curricula for police, prosecutors, judges and probation officers.
- Number of training events and number of trainees of the various professional profiles compared to overall training needs and total number of staff involved in treatment of PWDUD.
- Trainings are systematically evaluated; evaluations show effectiveness and sustainability.
- Occasions where judges have solicited support from experts on DUD in comparison to the total number of cases involving offenders with DUD.

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

Screening for and identification of DUD in persons newly admitted to prison is a prerequisite for all further steps of specific care and treatment of PWDUD. Primary healthcare (PHC) professionals play a central role in the care of PWDUD in prison. They need to be trained in screening for and identifying PWDUD upon admission, and catering to possible immediate treatment needs, such as withdrawal symptoms, while working to prevent self-harm and suicide. PHC professionals need to be able to make informed decisions about referral to specialised treatment such as psychiatric care and treatment of infectious diseases, and be sufficiently informed about risks and available harm reduction programmes.[10] In addition to training of healthcare professionals, training should be provided to all prison staff so they understand these concepts.

In some penitentiary systems, general practitioners in prison have been successfully trained to conduct OAT because specialists in treatment of PWDUD have not been continuously available in prison. OAT, also referred to as MAT of opioid use disorders, is currently the most effective treatment for people with opioid use disorder (PWOUD). International organisations (e.g. the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, World Health Organization, United Nations Office on Drugs and Crime) therefore recommend that it be offered to PWOUD, including within criminal justice systems. Although it has been shown to be effective even without accompanying psychosocial treatment, optimally it should be combined with psychosocial therapy. However, the complexity of OAT requires thorough training and licensing of therapists.

Strategies for training on screening of drug use disorders upon admission

PHC professionals should play a major role in identifying PWDUD through screening during the medical examination upon admission. A national DUD expert should assess the training needs of PHC professionals with regard to screening for DUD.

9. Examples of international training material include: UNODC (Treatnet), "Drug dependence treatment: interventions for drug users in prison", available at www.unodc.org/docs/treatment/111_PRISON.pdf; UNODC, *Treatment training package*, available at www.unodc.org/unodc/fr/treatment-and-care/treatnet-training-package.html; Harm Reduction EU, *Harm reduction in prison*, available at https://e.harmreduction.eu/course/view.php?id=3; WHO/UNODC (2018), "Treatment and care for people with drug use disorders in contact with the criminal justice system. Alternatives to conviction or punishment", available at https://cdn.who.int/media/docs/default-source/substance-use/unodc-who-alternatives-to-conviction-or-punishment-2018.pdf, all accessed 4 November 2022.
10. An overview of the scope of healthcare professionals upon admission can be found in: Lehtmets A. and Pont J. (2014), *Prison health care and medical ethics*, Council of Europe Publishing, Strasbourg, available at https://book.coe.int/en/penal-law-and-criminology/6882-pdf-prison-health-care-and-medical-ethics.html#, accessed 4 November 2022.

Activities:

Provide training to PHC professionals and other staff involved in interviews/evaluations upon admission on screening for DUD and screening tools (e.g. WHO ASSIST).[11]

Results of screening for DUD should become an obligatory part of the medical examination on admission form.

Encourage and invest in qualitative and quantitative research that increases understanding of the characteristics of local drug use in prison settings, for example in co-operation with local universities.

Indicators:

Results of screening for DUD have become an obligatory part of the medical examination on admission form.

Clear statistics on the prevalence of DUD are derived from medical documentation.

Increased number of PWDUD are offered and included in treatment programmes.

Strategies for training and licensing of primary care physicians in prisons on opioid agonist treatment

Given the scarcity of psychiatrists and drug therapists in the penitentiary institutions of most SEE countries,[12] PHC physicians should also be trained to acquire the necessary knowledge and skills in providing OAT and, if required by national law, become licensed for it.

A national DUD expert should assess existing OAT programmes in the community and the criminal justice system of the country by considering the following:

- Which organisations/institutions (ministries, NGOs, etc.) are responsible for/sponsors/organisers of OAT programmes? Are they able/willing to support/adapt/disseminate them to the criminal justice system?
- What training facilities (trainers, training material, curricula) do they use, and can these be adapted/disseminated for use in the criminal justice system?
- Which national and international (e.g. Council of Europe, European Monitoring Centre for Drugs and Drug Addiction, UN Office on Drugs and Crime) training material can be adapted (translated) for training on OAT in the criminal justice system of the country?

Activities

Overcome existing resistance (e.g. by PHC professionals, prison administration, politicians) to training on and implementation of OAT in the criminal justice system by:

- providing information on the scientific evidence, effectiveness and cost-efficiency of OAT based on international recommendations;
- undertaking professional advocacy, using technical assistance from professional advocacy experts to select the best possible advocacy methods and tools (e.g. conferences, university programmes, media, influencers, political lobbying).

Implement/roll out training on OAT by prioritising newly employed healthcare professionals and those in penitentiary institutions with the highest prevalence of PWOUD.[13]

Indicators

Documentation of the conducted training events and number of trainees participating in/obtaining accreditation for providing OAT;

Implementation/spread of OAT programmes for PWOUD in penitentiary institutions with the involvement of trained staff, as recommended in the international standards documents, that is continuation of OAT at imprisonment, enrolment into OAT programmes during time served in prison and preparation for seamless continuation of OAT following release.

11. WHO (2010), "The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Manual for use in primary care", available at https://apps.who.int/iris/bitstream/handle/10665/44320/9789241599382_eng.pdf;sequence=1, accessed 4 November 2022.
12. With the exception of Cyprus and Slovenia, which report that OAT in prison is sufficiently managed by mental health experts from community services, most other countries in the region report a considerable lack of mental health professionals who could adequately cover OAT in prison.
13. For example, tender offers for PHC physicians for Austrian prisons include the requirement of completed training in OAT or the readiness to undergo training in OAT.

3. Ensure continuity of care following release through information sharing and co-operation with health services, including the availability of take-home naloxone programmes upon release from prison to reduce the risk of death

Continuity of care for PWDUD after release from prison ("aftercare") includes preparation and advice before release, whenever possible provided by future caregivers from the community, with regard to accommodation, employment, and social registration and coverage/insurance after release, as well as continuation of psychosocial care and MAT. In particular, medical information should be provided about the high risk of a fatal drug overdose due to loss of tolerance in the days immediately following release. To avoid this potentially fatal event, seamless continuation of OAT and take-home programmes of naloxone (a life-saving medication in the event of an overdose) or, alternatively, long-release medication, should be made available.[14] Continuity of care requires close co-operation with community institutions and services for PWDUD.

Assessment

A DUD expert should consider which of these measures are in place and which ones should be implemented/enhanced.

- Is there a structured programme for continuity of care upon arrival and release from prison? Does it include care by social workers and medical staff (e.g. medical examination and advice before release; handover of a medical report)? Do standard operating procedures exist for preparation of release?
- Are social services from the community contacted in a timely manner before release in order to prepare for accommodation, registration, employment and social coverage/insurance?
- Are representatives from community social services allowed to personally contact PWDUD in prison before their release?
- Is the continuation of OAT safeguarded after release through external OAT services?

Activities

Train selected penitentiary staff in organising/supervising individual continuity of care management and in communicating with the relevant stakeholders.

Induce/enhance networking, co-operation and collaboration between the prison service and relevant ministries, probation services and NGOs involved in care for PWDUD for continuity of care after release.

Ensure seamless continuation of OAT provision by public healthcare services or NGOs for PWOUD enrolled in OAT in prison upon their release. Consider the introduction of depot buprenorphine injections for bridging OAT interruption upon release.

Engage in professional advocacy for naloxone take-home programmes using technical assistance from professional advocacy experts to select the best advocacy methods and tools (e.g. conferences, media, influencers, political lobbying), based on published international standards and recommendations.

Provide training in emergency naloxone application for PWOUD in the criminal justice system and for penitentiary staff.

Promote and engage in discussion on implementing naloxone take-home programmes.

Indicators

Established preparation for release procedures and a standard operating procedure thereof.

Established communication/co-operation channels with community services involved in the aftercare of released PWDUD.

Naloxone training events conducted.

Implementation of naloxone take-home programmes is on the agenda of decision makers.

Naloxone take-home programme advocacy events conducted.

Reduction of post-release mortality documented.

14. A summary of prevention of fatal drug overdose after release can be found in WHO (2014), "Preventing overdose deaths in the criminal-justice system", available at www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf.accessed 4 November 2022.

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

It is difficult to address drug treatment and drug use in prison without addressing criminalisation, considering that prison is the last instance in the criminal justice system that comes into contact with a person in need of treatment. Laws criminalising use or possession for personal use are a longstanding part of state responses to drugs. While such laws are intended to improve the health of the population, they are seen by many as a driver of health and human rights problems, including increased stigma and marginalisation. For example, criminal records can have long-term effects on welfare and opportunities. Laws may also criminalise the carrying of equipment necessary for risk and harm reduction services, such as sterile needles.

Across the European region, people incarcerated for drug-related offences make up a large proportion of the prison population. The majority of convictions are for non-violent offences. As a result, an increasing number of countries are implementing alternatives to criminalisation and/or punishment to address health and human rights concerns. These alternatives are permissible and encouraged under the United Nations drugs conventions and constitute positive human rights practice.

It is important to understand with regard to legal standards that DUD are health disorders that require treatment rather than punishment. The principle of proportionality requires in first-time offences and minor offences involving PWDUD the adoption of this approach "treatment rather than punishment" whereas imprisonment should remain the last resort. Increasingly, it is acknowledged that prisons are not necessarily the most appropriate setting for treatment and recovery compared to community-based options. In addition, incarceration of PWDUD has been shown to considerably increase the risk of spreading transmittable diseases in prison and to the community.

Therefore, legal provisions for non-custodial sanctions for PWDUD offenders 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 and sentencing practices for PWDUD offenders should resort to these structures to the maximum extent possible. Likewise, application of pre-trial detention should be reduced to the minimum extent possible, which may require awareness raising in and training of judges.

Appropriate legal regulations are also required to enable internationally recognised and recommended harm reduction and treatment measures for PWDUD in prison,[15] such as access to condoms and lubricants, needle/syringe exchange programmes, and permission for opioid agonist prescription in prison for MAT for opioid use disorders.

Assessment

An expert on national legislation should assess the national penal law and national sentencing practice with regard to compliance with international recommendations[16] to ensure that:

- DUD are regarded as health disorders and not as criminal offences and drug consumption and possession in PWDUD are regarded as separate from sentencing for drug trafficking;
- in first and minor offences of PWDUD treatment and non-custodial measures are applied whenever possible;
- imprisonment can be suspended or early release provided in favour of and as motivation for undergoing treatment of DUD.

The expert should assess which non-custodial sanction measures are established in the country and to what extent they are used by courts in sentencing PWDUD, identifying those that are missing, according to international standards and recommendations.[17] Barriers to the

15. UNODC/ILO/UNDP/WHO/UNAIDS (2013), "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions", Policy Brief, available at www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf, accessed 4 November 2022.
16. Drug Policy Alliance (2015), "Approaches to decriminalizing drug use & possession", available at www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Approaches_to_Decriminalization_Feb2015_1.pdf, accessed 4 November 2022.
17. Council of Europe Recommendation CM/Rec(2017)3 of the Committee of Ministers on the European Rules on community sanctions and measures, available at https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680700a5a, accessed 4 November 2022; Geiran, V. and Durnescu, I. (2019), "Implementing community sanctions and measures", Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/implementing-community-sanctions-and-measures/1680995098, accessed 4 November 2022.
Heard C. and Fair, H. (2019), "Pre-trial detention and its over-use. Evidence from ten countries", Institute for Crime & Justice Policy Research, London, available at https://prisonstudies.org/sites/default/files/resources/downloads/pre-trial_detention_final.pdf, accessed 4 November 2022.

realisation of international standards and recommendations on harm reduction measures in prison in penal law and bylaws should also be identified.

Activities

Promote, using technical assistance from professional advocacy experts to select the best possible advocacy methods and tools (conferences, media, influencers, political lobbying), professional advocacy to members of legislative bodies and courts to have these principles reflected in penal law and in sentencing practice.[18]

Implement/strengthen alternative non-custodial sanction measures such as diversion by warnings, mediations, fines, community sanctions, early release options in exchange for treatment, probation services, restorative justice and referral to treatment.

Train police officers, prosecutors and judges on DUD and the importance of avoiding detention and incarceration of PWDUD by resorting to non-custodial measures to the maximum extent possible.

Train penitentiary practitioners on the importance of harm reduction measures in prison.

Indicators

Penal law revised or its revision is present on the national agenda.

Non-custodial sanction measures established/implemented/increasingly used.

Number of imprisoned PWDUD reduced.

Harm reduction measures in compliance with international standards and recommendations implemented/considered for implementation.

Police officers, prosecutors and judges are aware of the effects of incarceration on PWDUD as well as the available non-custodial measures, and make use of them.

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

For the treatment of imprisoned PWDUD, just as for the treatment of any other health disorder, healthcare governance in prison may play a crucial role with regard to the professional independence of healthcare providers, a cornerstone for high-quality healthcare in prison. In addition to legal guarantees for clinical independence, healthcare governance taken away from the responsibility of the prison director and transferred to prison health departments subordinated directly to the ministry of justice or transferred to the ministry of health or public health authorities, increases the clinical independence of healthcare providers from penitentiary administrations and provides for healthcare budgets independent and separated from the competing financial needs of the general prison budget. However, both services should collaborate constructively in the best interests of health in prisons. Several European countries have legally and administratively undertaken these transitions in the last few decades. Nevertheless, before any administrative shift of prison healthcare responsibility is undertaken, safeguards must be installed to ensure that the necessary human and material resources are in place and care for imprisoned patients is on par with that provided to the community, particularly if the responsibility is shifted to the ministry of health.[19, 20, 21]

18. An example of successful good policy is the revised penal law 30/2000 from Portugal, in EMCDDA (2011), "Drug Policy Profiles. Portugal", available at www.emcdda.europa.eu/system/files/publications/642/PolicyProfile_Portugal_WEB_Final_289201.pdf, accessed 4 November 2022.
19. UNODC/WHO (2013), "Good governance of prison health in the 21st century. A policy brief on the organization of prison health", available at www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf, accessed 4 November 2022.
20. Pont, J. and Harding, T. (2019), "Organisation and management of health care in prison", Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69, accessed 4 November 2022.
21. Pont, J. et al. (2018), "Prison health care governance: guaranteeing clinical independence", *American Journal of Public Health* 108, pp. 472-6, available at www.ncbi.nlm.nih.gov/pmc/articles/PMC5844391, accessed 4 November 2022.

Assessment

Assessment should take place of the clinical independence of healthcare provision from the prison director and staff.

Are all clinical decisions in the care of PWDUD exclusively taken by the responsible healthcare professional and not overruled or ignored by non-medical prison staff?

Is there a healthcare budget separate from the general prison budget?

Activities

If healthcare in prison remains the responsibility of prison directors, instigate a discussion with the penitentiary administration and decision makers in the line ministry proposing to relieve prison directors of a competency that falls outside of their professional profile, and subordinate it to an independent central healthcare department with adequate professional healthcare expertise.

Ensure careful preparation for any administrative shift of responsibility for healthcare in prison and put in place safeguards guaranteeing appropriate human and material resources for the administrative body taking over prison healthcare.

Promote professional advocacy to members of legislative bodies, ministries involved in care of PDL, the ministry of health, administration experts and prison healthcare professionals for considering and implementing the above.

Indicators

Clearly defined and regulated clinical independence from prison directors is achieved for all healthcare needs of PWDUD, as for any other patients.

Responsibility, organisation, budgeting and planning of healthcare for imprisoned PWDUD is managed by a central healthcare department independent of prison director's authority.

6. Provide treatment opportunities for PWDUD who consume substances other than opioids or choose not to take MAT while incarcerated, in particular by implementing prison-based TC or closed TCs outside prisons

Apart from pharmacological treatment, psychosocial interventions are an effective way of identifying and addressing substance use disorders. The TC method is a well-developed treatment approach aimed at treating substance use disorders, which can be easily adapted to the prison environment to address the needs of those who decide to abstain from drug use or use substances other than opioids. TCs provide a drug-free environment in which people with substance use disorders live together in an organised and structured way that promotes change and enables them to live a life in full control of their addiction, in the outside world. It offers a methodology that has been introduced worldwide and modified to suit local cultures, settings and traditions. A TC consists of a combination of behavioural and psychological interventions to help the resident change from a lifestyle structured by the need to use drugs to a life without drugs.[22]

Residential treatment in the framework of a TC can be provided in dedicated units within a prison. Such programmes are particularly valuable when targeting specific high-risk populations, such as young offenders, women and people with psychiatric disorders. Having a dedicated residential environment minimises exposure to people, especially in the general prison population, who might victimise the individual undergoing treatment. This dedicated space also helps to target issues pertinent to the subgroup (such as addressing trauma among women who have survived harmful events). A TC is a model of residential treatment that can be adapted to a prison population in a cost-efficient way, making use of the time of incarceration as well as space and material provided for by the state (bed space, meals, heating, security, etc.).[23] Prison-based TC programmes should be located in a separate unit of the prison with a structure and services similar to comparable programmes outside the prison setting. If this is not possible, PDL should be given access to a closed TC in the community.[24]

22. Pompidou Group (2021), *Prison-based therapeutic communities (TCs): a handbook for prison administrators, treatment professionals and trainers*, Council of Europe Publishing, Strasbourg, available at https://rm.coe.int/2021-ppg-prisontc-handbook-eng-web/1680a2abe6, accessed 4 November 2022.
23. A case study on implementing the first in-prison TC in the Republic of Moldova is included in the Pompidou Group's Handbook.
24. This has been achieved in Cyprus, with the permission of the Attorney General.

Assessment

With the support of a TC expert and the penitentiary department, assess which penitentiary institution(s) in the country have the premises, infrastructure and allocated staff to provide separate units within the institution for a TC, with special consideration of the feasibility and sustainability of implementation, including whether any legal/ procedural provisions need to be changed for its full operation.

Assess the availability of possible managers, treatment professionals and trainers for TC in the penitentiary system and possible professional and human resources support from TCs operating in the community.

Activities

Start implementing a prison-based TC in a selected prison suited for that purpose.

Provide basic training on TC for treatment professionals, managers and trainers and implement ongoing training, evaluation and quality control.

If a prison-based TC cannot be implemented in the country, access to a closed TC in the community for PDL with DUD should be enabled through legal regulations.

Indicators

Prison-based TC implemented.

If prison-based TCs are not possible, access to closed TCs in the community for PDL with DUD is enabled.

Checklist of accomplished assessments, activities and achievements

This checklist contains ideas and proposals for improving implementation of the six recommendations pre-selected by the South-East Europe Co-operation Group on developing comprehensive drug treatment systems in prisons, based on their concerns and priorities. It has been drawn up with a view to the role and influence of the main target audience of this guidance paper in improving treatment and care of PWDUD: policy makers, representatives of national prison administrations directly involved in the design, implementation and evaluation of programmes and policies related to drug treatment and rehabilitation in the criminal justice system, and professionals (social and healthcare staff, law enforcement, court staff, etc.) working with PWDUD in the criminal justice system.

The aim of the checklist is to understand the dimensions of the challenges, barriers and opportunities at hand. It also allows assessment of the current situation and invite discussion, debate and further co-operation across responsible institutions. The checklist therefore presents exploratory questions inviting action, rather than indicators that require responses based on data.

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

1.1 Assessment	Accomplished	
	Yes	No
Is the content of existing training curricula in line with international guidance documents presenting evidence-based knowledge related to treatment of people with drug use disorders (PWDUD)? (see literature review in the background document P-PG/SEE-Prison (2021) 2_REV)	☐	☐
Is the adequacy of training coverage, qualification of current trainers and need for further education/training of trainers (ToT) assessed?	☐	☐
Do training activities on drug use disorders (DUD) target: – penitentiary healthcare staff (primary care professionals, psychiatrists, psychologists, drug therapists);	☐	☐
– other prison staff, i.e. social workers, police/security officers;	☐	☐
– prosecutors, judges and probation officers	☐	☐
Is effectiveness (i.e. trainees demonstrating increase of knowledge/benefit for their daily work) and sustainability (i.e. being affordable in terms of time and financial investment and meeting the needs of trainees and those in treatment) of trainings evaluated?	☐	☐
Do courts have an expert on DUD available supporting them in decisions on offenders with DUD?	☐	☐
Comments:		

1.2 Activities	Accomplished	
	Yes	No
Are steps being taken to inform and motivate the above target groups on entering training on DUD targeting:	☐	☐
– penitentiary training centres;	☐	☐
– ministries of justice, health and the interior;	☐	☐
– medical and juridical faculties of universities and professional boards;	☐	☐
– training centres/academies for judges, prosecutors, legal professionals and police?	☐	☐
Are courts actively encouraged to appoint/make use of an expert on DUD to take informed decisions on offenders with DUD?	☐	☐
Are interdisciplinary workshops on PWDUD organised, bringing together relevant staff with different professional backgrounds in the criminal justice system?	☐	☐
Is there a contact list of national/international institutions, non-governmental organisations (NGOs) and/or a pool of experts that can provide state-of-the-art input and/or trainers for designing and implementing training activities?	☐	☐
Is there a procedure in place that ensures that ToT is cascaded further and that trainers are selected from various professional backgrounds, making sure that all concerned staff benefit from training?	☐	☐
Are training activities corroborated and sustained by adopting associated guidelines and standard operating procedures and by periodic assessment of whether training needs are being met?	☐	☐
Comments:		

2. Consider specialised training for screening of DUD upon admission, and training and licensing of primary care physicians in prisons on opioid agonist treatment (OAT)

2.1 Assessment	Accomplished	
	Yes	No
Are the training needs of PHC professionals with regard to screening for DUD assessed, preferably by a national DUD expert?	☐	☐
Are training programmes on OAT assessed, preferably by a national DUD expert, with a view to their usability for primary healthcare (PHC) physicians in the prison system?	☐	☐
Are the responsible organisations/institutions/ministries able and willing to support/adapt/spread OAT programmes in the criminal justice systems?	☐	☐
Do or can the above-mentioned organisations/institutions/ministries make their relevant training resources (trainers, training material, curricula) available for use in the criminal justice system?	☐	☐

Have you identified national and international training material that can be adapted (translated) for training on screening and OAT in the criminal justice system of your country?	☐	☐
Comments:		

2.2 Activities	Accomplished	
	Yes	No
Training needs of PHC professionals with regard to screening for DUD		
Is state-of-the-art training provided on screening for DUD upon admission and screening tools (e.g. WHO ASSIST) to:		
– PHC professionals;	☐	☐
– other staff involved in the screening process	☐	☐
Are the results of screening for DUD an obligatory part of the form of medical examination on admission?	☐	☐
Do you encourage and invest (time or financial resources) in research that increases the understanding of local drug use in prison settings (e.g. in co-operation with local universities)?	☐	☐
Training and licensing (if legally required) of primary care physicians in prisons on OAT		
Are efforts made to overcome existing resistance to training on and implementation of OAT in the criminal justice system by:		
– providing information on the scientifically proven effectiveness and cost-saving benefits of OAT based on international recommendations;	☐	☐
– soliciting technical assistance from professional advocacy experts in selecting the best possible advocacy methods and tools for influencing decision making on delivering OAT;	☐	☐
– prioritising newly employed healthcare professionals and those placed in penitentiary institutions with the highest prevalence of people with opioid use disorder (PWOUD) when implementing training on OAT?	☐	☐
Comments:		

3. Ensure continuity of care following release through information sharing and co-operation with health services, including the availability of take-home naloxone programmes upon release from prison to prevent mortality

3.1 Assessment	Accomplished	
	Yes	No
Is there a framework in place to ensure continuity of care upon arrival in and release from prison?	☐	☐
Does the framework include care by social workers and medical staff (e.g. medical examination and advice before release, handover of a medical report)?	☐	☐
Do standard operating procedures exist for preparation of release?	☐	☐
Is there established co-operation with social services from the community responsible for organising accommodation, registration, employment and social coverage/insurance?	☐	☐
Do representatives from community social services have the possibility of personally contacting PWDUD in prison before their release?	☐	☐
Is the continuation of medication-assisted treatment (especially OAT) or psychosocial support ensured after release through community-based services?	☐	☐
Are there any programmes/initiatives directed at preventing overdose death following release among PWOUD, such as provision of take-home naloxone upon release?	☐	☐
Comments:		

3.2 Activities	Accomplished	
	Yes	No
Is training/support available for selected penitentiary staff on organising/supervising individual continuity of care management and on communicating with the relevant community-based services?	☐	☐
Are there opportunities/occasions created for inducing/enhancing networking, co-operation and collaboration between prison services and responsible ministries, probation services and NGOs involved in care for PWDUD after release?	☐	☐
Are social services from the community contacted in a timely manner before release in order to prepare for accommodation, registration, employment and social coverage/insurance of released prisoners?	☐	☐
Are community-based providers contacted in a timely manner to ensure seamless continuation of OAT provision and other pharmacological or psychosocial support by public healthcare services or NGOs after release of PWDUD from prison?	☐	☐
Where organisation of immediate continuity of OAT after release is not possible, are depot buprenorphine injections available for bridging OAT interruption upon release?	☐	☐

Do you engage professional advocacy experts to introduce naloxone take-home programmes for PWOUD in line with international experience and recommendations?	☐	☐
Is training provided in naloxone emergency application for PWOUD in the criminal justice system and for penitentiary staff?	☐	☐
Comments:		

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

4.1 Assessment	Accomplished	
	Yes	No
Is compliance of national penal law and practice with international recommendations verified and demonstrated, in particular so that:		
– illegal trafficking rather than DUD is sanctioned as a criminal offence;	☐	☐
– in the first and/or minor offences of PWDUD, treatment and non-custodial measures rather than incarceration are applied whenever possible;	☐	☐
– imprisonment may be suspended, or early release is offered in favour of and as a motivation for undergoing treatment of DUD?	☐	☐
Is it systematically assessed and documented which non-custodial sanction measures are established in the country, to what extent they are used by courts in sentencing PWDUD, and which non-custodial measures are missing according to international standards and recommendations?	☐	☐
Has assessment and documentation taken place of which barriers in penal law and bylaws exist that work against the realisation of international standards and recommendations on harm reduction measures in prison?	☐	☐
Comments:		

4.2 Activities	Accomplished	
	Yes	No
Are the results of assessment of compliance with international recommendations used through different advocacy methods and tools (conferences, media, influencers, political lobbying), possibly with the help of professional advocacy experts, to encourage/incite members of legislative bodies and courts to have these principles reflected in penal law and in sentencing practice?	☐	☐

Are alternative non-custodial sanction measures, such as diversion by warnings, mediations, fines, community sanctions, early release options in exchange for treatment, probation services, restorative justice and referral to treatment promoted?	☐	☐
Are training/sensitising activities and workshops on DUD organised for police officers, prosecutors and judges, underlining the importance of avoiding detention and incarceration of PWDUD by resorting to the maximum extent possible to non-custodial measures, making use of the expertise and training material of prison staff?	☐	☐
Are penitentiary practitioners and policy makers trained on the importance of harm reduction measures in prison and ways of advocating for their necessity?	☐	☐
Comments:		

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

5.1 Assessment	Accomplished	
	Yes	No
Have prison directors been relieved of the responsibility for healthcare in prison by transferring this responsibility to a health directory independent from the prison?	☐	☐
Is clinical independence of healthcare provision from the prison director ensured, in particular that:		
– all clinical decisions concerning the care of PWDUD are taken exclusively by the responsible healthcare professional and not overruled or ignored by non-medical prison staff;	☐	☐
– the healthcare budget is separate from the general prison budget?	☐	☐
Comments:		

5.2 Activities	Accomplished	
	Yes	No
If prison healthcare still falls within the jurisdiction of prison directors, have discussions been instigated between the penitentiary administration and relevant decision makers proposing to relieve prison directors of a competency that falls outside of their professional profile, and subordinate it to an independent central healthcare department with adequate professional healthcare expertise?	☐	☐

Have clear regulations and safeguards been put in place in prisons to ensure that all clinical decisions in the care of PWDUD are exclusively taken by the responsible healthcare professional and not overruled or ignored by non-medical prison staff?	☐	☐
Has a proposal been prepared with input from the prison administration for operationalising any shift of responsibility for prison healthcare, and for ensuring that the administrative body taking over prison healthcare has appropriate human and material resources?	☐	☐
Comments:		

6. Provide treatment opportunities for PWDUD who consume substances other than opioids or choose not to take MAT while incarcerated, in particular by implementing prison-based therapeutic communities (TC) or closed TCs outside prisons

6.1 Assessment	Accomplished	
	Yes	No
Is it carefully assessed in which prison and how a TC can be introduced in a sustainable manner?	☐	☐
Has it been identified if any legal/procedural changes need to be initiated for upscaling/replicating the TC programme in the prison system?	☐	☐
Is there proper infrastructure available in the detention facility selected for the introduction of a residential TC programme, including the availability of space, management, security and treatment professionals?	☐	☐
Is professional and human resources support from TCs run in the community possible?	☐	☐
Comments:		

6.2 Activities	Accomplished	
	Yes	No
Has a feasibility study been carried out to identify suitable locations, staffing and financing for implementing a TC?	☐	☐
Has an implementation plan been drawn up, covering necessary refurbishment, training, dedicated human and financial resources as well as the necessary legislative/procedural changes to ensure smooth implementation of the TC?	☐	☐
Is training on TC for treatment provided for the professionals, managers and trainers engaged with the TC philosophy and programme, including evaluation and quality control?	☐	☐

Have connections been established between prison-based TCs and any existing community-based TCs (e.g. through a co-operation agreement)?	☐	☐
If a prison-based TC cannot be realised, is access to a closed TC in the community for people deprived of liberty with DUD provided for by respective legal regulations?	☐	☐
Comments:		

This guidance paper has been elaborated together with nominated working group members of the Pompidou Group's South-East Europe Co-operation Group on "Developing comprehensive drug treatment systems in prisons" as a strategic tool for raising treatment standards for people with drug use disorders in the criminal justice system. Based on the international recommendations summarised in the background paper "Standards for treatment of people with drug use disorders in custodial settings", it targets policy makers, prison administrations and professionals involved in the care and treatment of people with drug use disorders in the criminal justice system focusing on the relevant legal framework, training, psychosocial and pharmacological treatment, and continuity of care. In this respect, the tool provides guidance in assessment, required activities and setting indicators for achieved standards supported by an instrumental checklist.

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