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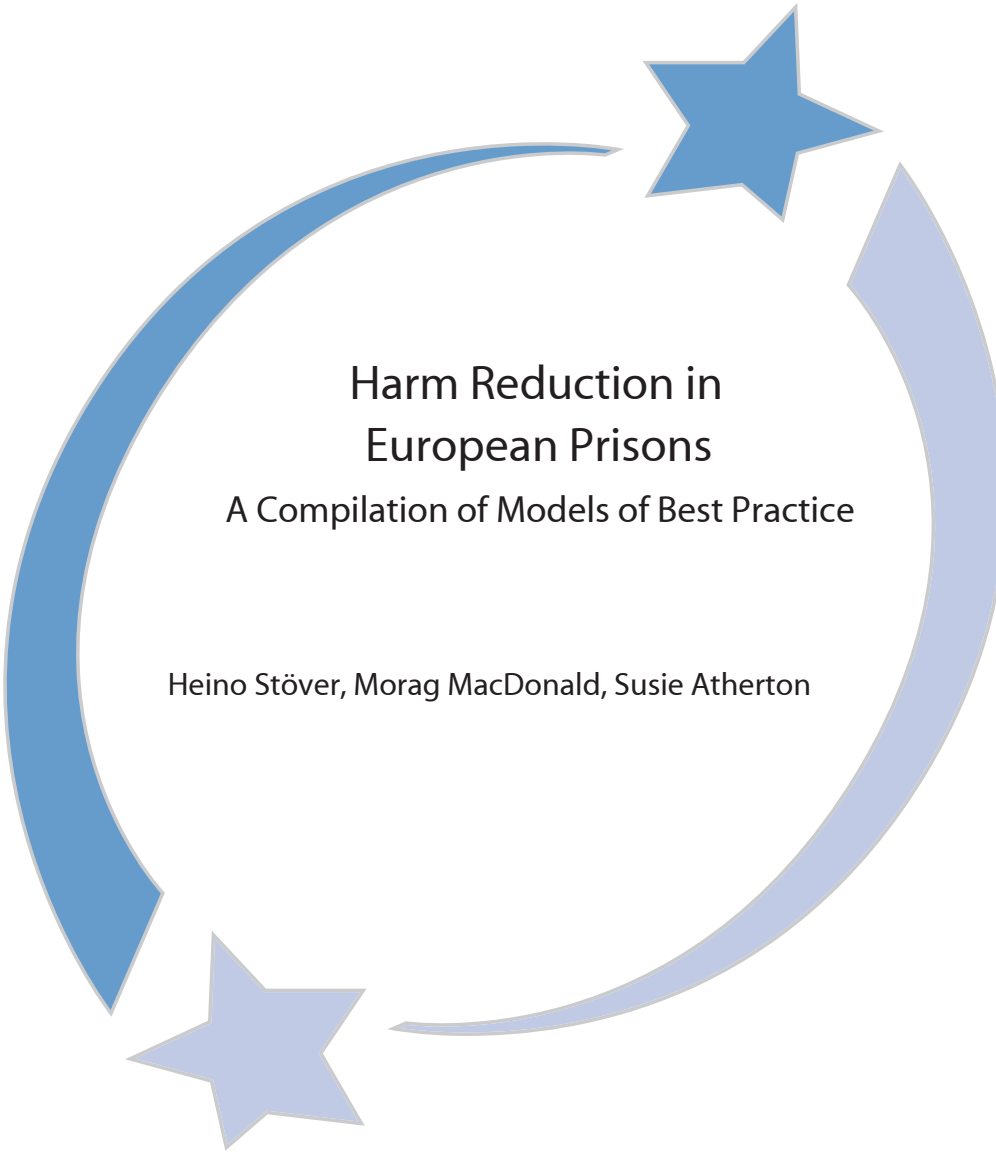

Cranstoun drug services

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Cranstoun Drug Services

Heino Stöver, Morag MacDonald, Susie Atherton

Harm Reduction in European Prisons

A Compilation of Models of Best Practice

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Contents

Acknowledgements **9**

List of Tables and Figures **11**

Executive Summary **13**

***Chapter 1* – Introduction** **25**

***Chapter 2* – Methodology** **27**

2.1 Methodological approach 27

2.2 Aims and objectives 27

2.3 Details of institutions visited and participants interviewed 28

2.4 Definition of key terms 30

2.5 Procedures and ethical issues 31

2.6 Methodological issues arising from the fieldwork 33

***Chapter 3* – Profiles of the prisons and NGOs visited – trends and responses to drug use in prisons in the sample countries** **35**

3.1 Prison population rate 35

3.2 Sentenced prisoners by main offence (drug offences) 35

3.3 Austria 36

3.3.1 General Overview 36

3.3.2 Prisons and NGOs visited 37

3.4 Bulgaria 38

3.4.1 General Overview 38

3.4.2 Prisons and NGOs visited 39

3.5 Estonia 40

3.5.1 General Overview 40

3.5.2 Prisons and NGOs visited 41

3.6 Germany 42
3.6.1 General Overview 42
3.6.2 Prisons and NGOs visited 43

3.7 Italy 44
3.7.1 General Overview 44
3.7.2 Prisons and NGOs visited 44

3.8 Lithuania 46
3.8.1 General Overview 46
3.8.2 Prisons and NGOs visited 48

3.9 Poland 48
3.9.1 General Overview 48
3.9.2 Prisons and NGOs visited 50

3.10 Romania 50
3.10.1 General Overview 50
3.10.2 Prisons and NGOs visited 51

3.11 Spain 52
3.11.1 General Overview 52
3.11.2 Prisons and NGOs visited 54

***Chapter 4* – Review of the literature 57**

4.1 High risk behaviour in prisons 57
4.1.1 Drug use in prison 57
4.1.2 Nature and prevalence of drug use and related risks in prisons 58
4.1.3 Injecting drug use and communicable diseases 62
4.1.4 Unprotected sex in prisons 64
4.1.5 Tattooing and body piercing 66

4.2 Prison as a high risk environment 67
4.2.1 Overcrowding and the over-representation of risk groups 68
4.2.2 The principle of equivalence for health care in prisons 69

4.3 Treatment, prevention and education programmes for prisoners 71
4.3.1 Testing of Infectious Diseases and HAART 72
4.3.2 Hepatitis vaccination 72
4.3.3 Drug testing 73

4.3.4 Information, education and communication for prisoners and prison staff 74
4.3.5 Prison based drug demand reduction programmes 77
4.4 Harm reduction in prisons 80
4.4.1 Needle exchange programmes in prisons 82
4.4.2 Political and moral resistance to prison based needle exchange programmes 84
4.4.3 Provision of substitution treatment 85
4.4.4 Provision of bleach and disinfectants 88
4.4.5 Provision of condoms, dental dams, and water-based lubricants 89
4.5 Training and engaging prison staff in implementing harm reduction services 91

***Chapter 5* – Identifying good practice models of harm reduction in prisons 95**

5.1 The provision of condoms – Austria, Estonia 96
5.2 Conjugal visits – Estonia, Spain 97
5.3 Through care – Italy 98
5.4 Rehabilitation programmes for drug users – Bulgaria 99
5.5 Partnerships with NGOs – Austria, Bulgaria, Estonia, Germany, Lithuania 99
5.6 HIV education through peer groups and NGOs – Romania, Spain 103
5.7 Substitution treatment – Austria, Spain, Poland 107
5.8 Prison based needle exchange programmes in Spain 112
5.9 Testing and treatment for communicable diseases – Austria, Lithuania 114
5.10 Training for healthcare staff – Germany 115
5.11 The provision of bleach – Austria 115
5.12 The provision of hygienic packs – Austria, Spain 116

Chapter 6 – **Barriers to the implementation of harm reduction in prisons and requirements to ensure sustainability** **117**

6.1 Overcoming institutional challenges 117

6.2 Overcoming abstinence orientation as pre-dominant response 119

6.3 Information, education and communication 120

6.4 Adjustments in regulations and legislation 122

6.5 Reduction of prison populations and prison reform 123

6.6 Commitment and political and management leadership 124

6.7 Overcoming resistance from prisoners and prison staff 125

6.8 Human rights legislation and international guidelines 127

6.9 The need for protocols, standards of care and guidelines 129

6.10 Continuity of treatment 130

6.11 Substitution treatment in prisons 134

6.12 Needle exchange programmes in prisons 135

Chapter 7 – **Conclusions** **137**

References **145**

Appendices **161**

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List of Tables and Figures

Table 1:	Details of the prisons visited in the sample countries	29
Table 2:	NGOs visited in the sample countries	29
Table 3:	Prison population and capacity rate for the sample countries	69
Figure 1:	Number of imprisoned persons dependent on drugs and psychotropic substances and their share (percent) of all imprisoned persons, 2001–2005	46
Figure 2:	Consumption prevalence of psychoactive substances in correction centres (2004)	53
Figure 3:	Evolution in the prevalence of HIV in prison population (Spain, 2001–2005*(%)	54
Figure 4:	Harm reduction services in prisons	82

Executive Summary

The key aim of this research was to provide an overview of the legislation, policy and practice concerning harm reduction services provided for problematic drug users (PDUs) in 9 European Union (EU) countries. To achieve this, the main objectives were to analyse international, national policies on harm reduction; to explore how harm reduction is conceptualised in different cultural contexts; to identify existing harm reduction initiatives in prisons; to identify the obstacles and barriers that need to be to overcome in order to implement harm reduction measures in prisons; to examine in detail the policies and harm reduction services in place in two sample institutions; to identify models of best practice and promote awareness of the harm reduction initiatives operating in the area of problematic drug users in custody, and finally to present examples of harm reduction measures in prisons from each of the sample countries.

Introduction

Harm reduction is an important public health measure because reusing and sharing needles or other equipment for preparing and injecting drugs represent a highly efficient method of transmitting HIV and hepatitis C. In the absence of harm reduction activities, HIV prevalence among injecting drug users can rise to 40% or more within one or two years after the virus is introduced in their communities. Harm reduction measures are highly politically loaded, cannot be introduced due to resistance of staff, or are perceived as inappropriate for the prison setting (e.g. needle exchange). The introduction of harm reduction measures is relatively new to prison systems and is often perceived as threatening to the traditional abstinence-oriented drug policy in prisons.

High risk behaviour in prisons

There are numerous studies which demonstrate that prisons and secure settings are facing increasing problems with drug use, sexual activity and other

high risk behaviours which can have serious health consequences (MacDonald, 2005; Pallas et al., 1999; Polonsky et al., 1994; Lines et al., 2004; Stöver, 2002). In addition, problematic drug users are among the most vulnerable prisoners, and are over-represented within the prison population, often due to a growing trend towards the criminalization of drug use and possession and the use of custodial sentences for drug-related crime, throughout the EU (EMCDDA[1], 2003) especially among young people (Muncie, 2005). There is a clear need for prison systems throughout the EU to acknowledge that the use of drugs and sexual activity occurs within their institutions, in order to prevent prison health problems becoming public health problems (Ramsay, 2003). In addition, preventative measures will be in-effective, if national prison administrations continue to refuse to acknowledge or to deal with drug use, sexual activity, tattooing and the associated health risks.

Injecting drug use and communicable diseases

In Europe the HIV prevalence among prisoners is primarily related to the sharing of injecting equipment inside and outside of prisons. Sharing syringes among intravenous drug users is a high-risk activity for the transmission of HIV due to the residual presence of blood in the syringe after injecting (Shah et al., 1996; Shapsak et al., 2000). Given the secure environment of penal institutions, it is often more difficult to smuggle syringes into prisons than it is to smuggle in drugs (Lines, 2002). As a result, syringes are typically scarce, and prisoners who inject drugs share and reuse syringes out of necessity (WHO, 2004).

Unprotected sex in prisons

Unprotected sexual contacts between prisoners pose a risk for the sexual transmission of HIV, Hepatitis and other sexually transmitted diseases. Within penal institutions, sexual contacts occur in different ways, and in varying frequencies. Sex maybe consensual, or it may be forced or coercive. Although homosexuality has been decriminalised in many countries, significant stigma is still attached to same-sex sexual activities (particularly male homosexuality) in many societies and in many prison systems.

1 European Monitoring Centre for Drugs and Drug Addiction.

Tattooing and body piercing

Tattooing amongst prisoners is a common practice in many countries (Bammann/Stöver, 2006). Research has revealed high levels of tattooing among prisoners in many countries including Australia (Dolan, 1999), Canada (Correctional Services Canada, 1996), Ireland (Long et al., 1999), Spain and the United States (Dolan, 1999). Tattooing is an activity that takes place secretively, often in unhygienic environments, using homemade equipment and inks, and as quickly as possible so as to minimize the risk of detection by prison staff. All of these factors increase the risk of negative health consequences via tattooing in penal institutions.

Treatment, prevention and education programmes for prisoners

Prison-based treatment programmes have a tendancy to focus on abstinence as the main goal as opposed to maintenance, as shown by a lack of substitution treatment programmes (Marlatt/Witkiewitz, 2002). Abstinence-based treatment programmes provide a good opportunity for those prisoners who are motivated and capable to cease using drugs. There is evidence that substitution maintenance treatment for heroin dependence (mainly methadone or buprenorphine treatment) is also effective. However, it is important to accommodate those prisoners who are not motivated to stop using drugs, but do need to better understand how to reduce the harms associated with drug use. Research has highlighted the need for treatment providers, in any setting, to identify the needs of clients and their goals, whether this be maintenance or abstinence, and provide support in accordance with this (Marlatt, Blume and Parks, 2001; Stöver et al. 2004).

Training and engaging prison staff in implementing harm reduction services

Harm reduction measures are often perceived as threatening to the traditional abstinence oriented drug policy (Cadogan, 1999). Harm reduction often is highly politically loaded, cannot be introduced due to resistance of staff, or are perceived as inadequate for the prison setting (MacDonald, 2005). With regards to substitution treatment in prisons, this is often in conflict with the notions of prisons as ‘drug free’ – a notion held by both staff and prisoners. Substitution drugs are seen not as therapeutic measures, but as street drugs and prisoners often engage in dealing and misusing such substances, along

with other prescription drugs Stöver et al., 2004). Regarding needle/syringe exchange schemes, similar objections are raised in that staff believe they will lead to an increase in intravenous drug use, an increase of accidental needle stick injuries, an increase in conflicts between prisoners or between prisoners and staff, and the risk that syringes/needles would be used as weapons or as goods within the prison economy. However, there is clear evidence that schemes have been introduced in prisons, for example in Switzerland, Spain and Germany, without these problems arising (see Stöver/Nelles).

Findings: Identifying good practice models of harm reduction in prisons

Implementation of harm reduction measures within prisons was seen as a key issue by many participants, as it emphasised the difficulties in working with a secure environment, with staff who are not always aware of the need for harm reduction and who often require additional training. These examples are generally indicative of innovative practice on an institutional level, rather than on national levels, as the prisons visited in the sample countries generally have control and autonomy over which strategies they employ, and how they do this.

Provision of condoms and lubricants

Condom provision was available in Austria and Estonia. Along with the distribution and easy access of condoms in Austrian prisons, recent legislation and policy has also dictated that all prisons should provide easily accessible places where condoms can be taken off anonymously. In some prisons the venue is the medical unit of the prison, but it is generally viewed as more advantageous to provide this service in each section of the prison. However, it is also important to address issues around the logistical problems implementing such a service, as this depends very much on ensuring staff engage and co-operate with this. It is generally believed that male prisoners are wary of being seen to use condoms within the prison as they do not want to be labelled as homosexual. Condoms are available throughout all prisons in Estonia, through the healthcare staff and in conjugal visit rooms within prisons. In addition, healthcare staff provide information to prisoners about why it is important to use condoms, with regards to preventing the spread of sexually transmitted diseases.

Conjugal visits

Conjugal visits are available in most prison systems, for example in Estonia, they form an important part of helping prisoners maintain contact with the outside world. They are available to prisoners once a month, but they have to be earned through good behaviour and prisoners demonstrating that they can be trusted. Staff based in the prisons visited generally viewed conjugal visits as important for the social rehabilitation of prisoners, and their wellbeing during their sentence. Conjugal visits are also available in Spanish and Catalynian prisons. In the visited prison of Cuatre Camins near Barcelona/Catalunyia the project is called VIS A VIS. Prisoners are allowed to receive visits two times a month for 1,5 hours. The prison aims to give prisoners the chance to maintain relationships to families and/or partners. The rooms are equipped with double bed, condoms are being laid out. Towels and bed sheets have to be brought in by partners. Shower facilities are provided. If prisoners are homosexual they may also receive visits from their partners.

Throughcare

Italy was selected as an example of good practice in throughcare for prisoners with problematic drug use as the drug treatment agency (Ser.T – Servizio Tossicodipendehze) working in prison also works in the community and can provide continuing treatment from the community into prison and on release from prison. Ser.T can also start drug treatment in the prison with prisoners who have had no previous contact with services in the community, and they can arrange drug treatment in the community as an alternative to a custodial sentence. The Ser.T in Padova works with 2 prisons with 1200 prisoners of whom 30% are identified as problematic drug users, and they work with both pre-sentenced and remand prisoners.

Rehabilition programmes

Rehabilitation programmes for drug users are available in Bulgaria, and the Prison Director at Varna Prison also emphasised the range of programmes available to prisoners, especially those from more vulnerable groups such as drug users, those with HIV, and other marginalised groups. These programmes include social skills training, re-integration for release, assertiveness training, conflict management and more long term programmes for those with mental illness. Prisoners can also receive more practical support,

such as how to deal with getting employment on release through the labour office and help with housing and financial support. These courses are particularly important as they help prisoners with problematic drug use to access social services and drug addiction services (if requested) in the community and helps them not to re-offend when they are released.

Working with NGOs

In Austrian prisons, in order to support the harm reduction oriented activities, the Ministry of Justice has introduced recommendations for prison administration and institution staff to collaborate with regional AIDS Self-Help Groups. These groups provide training and lectures for staff members and for prisoners, care for prisoners and problem-oriented working with prisoners. Another important element of recent strategy is cooperation with a counselling agency (MEN), which includes a team of psychologists and a doctor discuss important issues raised by prisoners (male only) with regard to their healthcare needs. These include general hygiene, nutrition and sexual health, and a key goal is to encourage prisoners to continue to seek this form of support on release. A similar programme for female prisoners is in development.

A project based at Varna prison in Bulgaria has been set up through links with an NGO (Varna Association of Non-Government Organisations for Drug Demand Reduction), to help both staff and prisoners (including drug users). It involves group sessions, individual consulting and peer support and training for security staff. It is well received by the prison staff as they recognise that it will provide an important service for prisoners, taking pressure off them to feel responsible for every aspect of prisoners' well-being.

In Estonia, the NGO Convictus have four main projects financed largely by the global fund, with 10% from SOROS and 7% from the government. They provide 15 support groups within prisons in Estonia; community based needle exchange and counselling programmes; a support group for ex prisoners and a support group for women injecting drug users and for those diagnosed as HIV positive. They are the only NGO who work constantly in prison and they have become an integral part of social work in the Estonian prison system.

In the two prisons visited in Lower-Saxony NGOs have mainly been integrated in the prevention work against HIV/AIDS and other blood-borne

viruses. In the women's prison of Vechta an organisation calles "Junkies/Ex-User/Substitutees (JES) comes into the prison monthly in order to contact women with a drug using background. These group meetings focus on awareness raising regarding risk behaviour in prisons; stimulating an exchange of knowledge and experiences; dissemination of prevention material; safer use training and advice for general problems. In the men's prison of Gross-Hesepe the local AIDS-Hilfe Emsland, visits the prison bi-monthly and offers an afternoon for interested detainees. The group meeting focuses on all aspects of living at risk in the prison setting and how to reduce harm, such as sexual contacts (men having sex with men); intravenous drug use; effective cleaning of needles and syringes and dissemination of material support in everyday life matters.

In Lithuania, the prison service has a link with an NGO, called 'Space of Life', which is a rehabilitation centre for problematic drug users, based in Kaunas. It organises group therapy for prisoners (who are motivated to cease drug use) and also provides social care after release. Staff in the NGO believe prisoners are more willing to participate in programmes in the community which are run by NGOs, compared to prison based programmes. They are also working hard to address the link between injecting drug use and HIV, through active participation in National Programme of Drug Prevention and Control, which includes infectious disease prevention (including sexually transmitted diseases). A consultant from the AA/NA (Alcoholics Anonymous and Narcotics Anonymous) groups has set up meetings with female prisoners at Panavesky prison, to help them in ceasing drug and/or alcohol use, but also to train prisoners to act as peer group educators. This has received very good co-operation from the staff at Panavesky prison and the national prison administration, and it also contributes to a pre-release integration programme. In training prisoners, it aims to make all the groups independent and continuous in the prison, so if voluntary NGO staff do not turn up the group can run itself and members of the group are also encouraged to continue meeting up, particularly when they are released, if this is possible.

Peer to peer education

Romania was selected as an example of good practice in the use of peer groups as part of HIV/AIDS interventions in prisons. The education programme for prisoners with problematic drug use involves information about

how to reduce the possibility of diseases via sharing needles, along with various programmes about drug use and the associated risks. Staff involved in the programme considered it to be particularly important to pay special attention to juvenile prisoners. A key part of the programme is using prisoners to act as peer educators, to inform other prisoners about the correct use of condoms and needles and to provide information about needle exchanges in the community.

External NGOs collaborate with Spanish (including Catalan) prisons in providing health education for prisoners. They also work with the central administration staff to follow up the outcomes of such programmes, for example peer educators providing information on healthcare, to measure their success. The key stages of this process are the creation of the Peers for Health Education Team in the prison, formed by doctor, nurse, psychologist, social educator, social worker, teachers and security staff of the prison, as well as NGO members; training of the team, by an external entity (NGO) with previous experience and technical skills. In Catalunya, the AIDS program of the Health Department finances four NGOs to help them with developing several programs in seven Catalan prisons. There are different kinds of programs, such as health education, emotional support, adherence to antiretroviral treatment, and intra/extra penitentiary coordination of sanitary services for HIV infected prisoners who are on antiretroviral treatment.

Substitution treatment

The basic goal of the Austrian prison policy is to provide prisoners with an access to health care services, which includes substitution treatment. At the time of the visit, there were 650 prisoners under substitution treatment. The provision of substitution treatment stems from orders of the Ministry of Justice, which states that it should be available in every Austrian prison.

All prisons in Spain offer initiation of methadone, methadone maintenance treatment, and detoxification with methadone. Brief and progressive detoxification may also be offered with opiates and benzodiazepines. Substitution treatment in prison has been developed as part of the harm reduction strategy since 1992, and was extended to all prisons in 1998.

The basic problem in introducing substitution treatment in prison is the fact that this treatment is not available across the whole of Poland. This has caused problems of delay in introducing this treatment because it cannot be

guaranteed that prisoners will be able to continue their treatment in the community once released. This is the key argument of experts and practitioners from the outside who argue that it is only justified to provide substitution treatment if it is possible to continue it in the community. Negotiations from Polish Prison Administration with community representatives have led to substitution treatment programmes being established at least in some prisons.

Every doctor involved in substitution treatment has to undergo a special course called addiction medicine – basic provisions (Bundesärztekammer, 1999). The Federal Medical Association has elaborated a 50 hour course which doctors have to undergo before they get involved in prescribing substitution agents. This counts for prison doctors as well. The curriculum of the course foresees an improvement of addiction specific knowledge, a challenge and assessment of the attitude towards addicted persons, improvement of psycho-social competencies of the doctor to make use of the resources of the patient and the ability to co-operate with non-medical professions. It is not solely directed towards the prescription of opiates but it is addressing all relevant drugs and addictions. The basic method taught is motivational interviewing, which is suggested to be applied in the dialogue with dependent patients.

Needle exchange programmes

As an example of the implementation process via protocols and frameworks the introduction process of needle exchange in Spanish prisons should be mentioned. In March 2002 the Ministry of the Interior and the Ministry of Health and Consumer Affairs jointly published the document Needle Exchange in Prison: Framework Program, which provides the prisons with guidelines, policies, and procedures, and training and evaluation materials for implementing needle exchange programs.

Provision of bleach

In all 28 Austrian prisons anonymous access (in most parts) to disinfectants in order to avoid the transmission of BBVs via sharing of needles and equipment is achieved. The Austrian Ministry of Justice stated in several orders (Erlass) that beside condoms, the disinfectant Betaisadona should be made available freely and anonymously in all prisons.

Hygienic packs

Increasing incidences of tattooing, the exchange of injection equipment, sexual activity and the high prevalence of infectious diseases were the rationale behind providing prisoners with a 'Take-Care-Package' in Austrian prisons.

In the prison visited in Spain, hygienic packs were given to the prisoners, which can be refilled. The hygiene pack was seen both by prisoners and by staff as an essential prerequisite for addressing hygiene to be an important issue for all prisoners. It was said by both groups that it serves as an 'appetizer' for talking about health issues.

Barriers to the implementation of harm reduction in prisons and requirements to ensure sustainability

To implement and maintain harm reduction measures in prisons, there are various challeges which must be overcome, such as overcoming institutional challenges, overcoming abstinence orientation as pre-dominant response, dealing with adjustments in regulations and legislation and overcoming resistance from prisoners and prison staff. In addition, there is a more general need to consider reducing prison populations and implementing prison reform, which requires commitment and political and management leadership. Developments in human rights legislation and international guidelines further emphasise the need for protocols, standards of care, which need to be sustainable and also contribute to establishing links with NGOs and community health services.

Conclusions

The key points based on the findings are:

- Throughout the EU, the introduction of harm reduction measures in prisons is still falling compared to developments achieved in the last 20 years in the community and in prison systems in other countries such as Australia and Canada (with the exception of Spain and partly Austria).
- In nearly all the prisons visited there was limited access to harm reduction measures like condoms, syringes or bleach, therefore prisoners are not granted equality of care, as in most countries, such services are available in the community.

- The need for continuity of care is particularly important for those receiving substitution treatment for drug use prior to their sentence, so they can continue with this treatment during their sentence.
- In all of the prisons visited respondents were aware of the over-representation of health risks of prisoners, however, the strategies to respond to these challenges differed in goals and methods.
- In all of the prisons visited health problems deriving mostly from injecting drug use afford extra efforts in policy and practice to tackle this severe problem in prison. This needs to be done in order to protect prisoners, staff, but also families and partners of prisoners in the community.
- As shown in several prison systems establishing effective working links between prison-based services and community services and NGOs is essential in implementing comprehensive harm reduction strategies in prisons.
- Learning from existing experience in developing harm reduction programmes in prisons, and using that knowledge to develop effective measures is an important strategy for prison administrations to adopt.
- National and international networking and exchange of good practice models seems to be a valuable method for all prison systems to engage in. In addition, international networks and journals need to disseminate internationally available good practice models and knowledge about evidence-based strategies into the prison settings and/or on the level of prison administration.
- The coercive, punitive ethos and abstinence-based policies (excluding substitution programmes) that currently underpins prison health policy in most countries must be removed. To view the prisoner as a patient seems to be the necessary shift to achieve this, for example for those prisoners with drug dependence, to see it as a disease rather than a criminal activity, subculture and hedonistic pleasure seeking behaviour.
- Governments must acknowledge the fact that respecting the rights of those at risk is good public health policy and good human rights practice. As increasing evidence demonstrates the detrimental impact of poor prison healthcare policy and practice on public health, this becomes a concern beyond that of prison administrations and criminal justice staff

and must be embraced by those responsible for wider social and health-care policy.

Chapter 1

Introduction

The European Network for Drugs and Infections Prevention in Prison (ENDIPP) and Cranstoun Drug Services commissioned research on Harm Reduction in European Prisons – A compilation of Models of Best Practice. The intention for the study was to update previous research (MacDonald, 2005) into the implementation of harm reduction in prisons by presenting models of good practice. The research adopted an ethnographic approach, using in-depth interviews and focus groups with prison staff and (former) drug using prisoners. Prisoners were asked about their drug using careers both in the community and possibly during their imprisonment and what harm reduction measures they had access to both in the community and in prison. Due to the sensitive nature of the research, clear ethical guidelines and confidentiality procedures and guarantees for the participants were developed prior to any fieldwork taking place (MacDonald, 2006).

A country co-ordinator was appointed in each of the sample countries, in order to assist with organising the fieldwork visit, to identify participants and facilitate interviews. They also assisted in identifying an independent translator, which was necessary to ensure confidentiality both to prison staff and to prisoners during the interviews.

The interview schedule used for the research was piloted by all three researchers, Morag MacDonald, Heino Stöver and Susie Atherton during the first fieldwork visit in Estonia during January 2006. The remaining fieldwork was carried out in Italy, Bulgaria and Romania by Morag MacDonald, in Austria, Poland, Spain and Germany by Heino Stöver and in Lithuania by Susie Atherton, during 2006.

Chapter 2 presents further details of the methodological approach used, the aims and objectives of the research, details of the institutions and organisations visited, definition of key terms, procedures and ethical issues and methodological issues arising from the fieldwork. Chapter 3 provides further

information on trends in drug use in prisons, details of the prison systems, institutions and NGOs visited in each country, in order to set the findings in context. Chapter 4 is a review of the literature of the key issues relating to drug use and other high risk behaviours in prisons, treatment and healthcare services for prisoners, environmental problems which arise in the prison setting and the use of harm reduction measures in prisons. Chapter 5 outlines models of good practice in harm reduction provision, identified in the sample countries, such as condom provision, bleach, needle exchange programmes, substitution treatment, peer education programmes and through-care for problematic drug users. Chapter 6 presents recommendations for developing guidelines to overcome barriers to implementing harm reduction measures in prisons and chapter 7 present conclusions from the findings.

Chapter 2

Methodology

2.1 Methodological approach

The focus of this study was to broaden knowledge and understanding of the different experiences and perceptions of the various participants, in the context of the different policies and practices in place. The findings are not intended to present generalisable data, but to reflect the different experiences of those involved with implementing harm reduction measures in prisons. Using the ethnographic approach allows the study to include various sources of data, including analysis of current policy and qualitative research to obtain data on how policy is put into practice.

2.2 Aims and objectives

The key aim of this research was to provide an overview of the legislation, policy and practice concerning harm reduction services provided for problematic drug users (PDUs) in 9 European Union (EU) countries. The objectives were:

- To identify existing harm reduction initiatives in prisons, which will be analysed on several levels: development, introduction, implementation, evaluation, and at the system-level.
- To identify the obstacles and barriers that need to be to overcome in order to implement harm reduction measures in prisons.
- To examine in detail the policies and harm reduction services in place in two sample institutions which address the needs of problematic drug users.
- To investigate the implementation process of harm reduction services currently offered to problematic drug users in the two sample institutions.
- To study perceptions of these harm reduction measures with all involved stakeholders (prison management, staff, prisoners).
- To identify models of best practice.

- To promote awareness of the harm reduction initiatives operating in the area of problematic drug users in custody.
- To present examples of harm reduction measures in prisons from each of the sample countries.

The research involved visiting, where possible, two prisons in each of the nine countries. Interviews were also conducted with NGOs working in the field of drug treatment and harm reduction, and in some cases, directly with prison administrations and institutions (see table 2). The countries involved in the research were Austria, Bulgaria, Estonia, Germany, Italy, Lithuania, Poland, Romania, and Spain. A questionnaire was sent to the national prison administration in Latvia for completion, as part of the distant data collection.

2.3 Details of institutions visited and participants interviewed

Prison visits took place in 19 prisons, which varied in the type of prisoners accommodated, i.e. males and females, adults and juveniles and pre-trial and sentenced prisoners (see table 1). Within the 9 countries visited there are a total of 818 prisons with a total population of 359,614 prisoners. Taking this background into consideration, clearly this study only offers a snapshot of harm reduction services available in prisons. In addition, this research is not intended to be comparative or representative, due to the differences in the way prisons are run, in each country and also in the legislation used to deal with offending and problematic drug use. The selection of national prison administration, individual institution and non-governmental organisation staff was dictated by the need to interview participants with specific roles and responsibilities. For the focus groups, this process was generally based on availability of prisoners and their suitability in relation to experience with problematic drug and alcohol use. The field visits, across the 9 countries, were conducted between January 2006 and September 2006, with each visit lasting 4 to 7 days, depending on the geographical location of the prisons and the agenda prepared by the country contact.

Table 1: Details of the prisons visited in the sample countries

Country	Prisons Visited	Type	Category of Prisoner
Austria	Stein Hirtenberg	Adultmale Adult male	Sentenced High Security Sentenced
Bulgaria	Varna	Adult male	Sentenced/pre-trial
Estonia	Tartu Harku Tallinn	Adult and juvenile male Females Adult males Adult females	Sentenced adult/pre- trial juvenile Sentenced/pre-trial Sentenced/Pre-trial Pre/trial
Germany	Groß Hesepe Vechta	Adult male Juveniles and adult female	Sentenced Sentenced/pre-trial
Italy	Padova Circondiarle San Vittore Bolatti	Adult male Adult male and female Adult male	Pre-trial Sentenced/pre-trial Sentenced
Lithuania	Vilnius Correction House (number 2) Panavesky	Adult male Female	Sentenced Sentenced/pre-trial
Poland	Lublin Warzaw Biawolowenka	Adult male Adult male	Sentenced/pre-trial
Romania	Colibash Prison Hospital Colibash Prison Giurgiu	Male Male, juvenile and female Male	Sentenced/pre-trial Sentenced/pre-trial women Sentenced
Spain	Quatre Camins de la Roca, Barcelona	Male	Sentenced

Table 2: NGOs visited in the sample countries

Country	NGOs and Governmental Organisations visited
Austria	Schweizerhaus Hadersdorf
Bulgaria	Varna Association of NGOS in Drug Demand Reduction
Estonia	CONVICTUS
Germany	AIDS-Hilfe Emsland
Italy	SERT
Lithuania	Space of Life and Alcoholics Anonymous
Poland	Monar Poland
Romania	ALIAT
Spain	Mediadores en salud

2.4 Definition of key terms

Harm Reduction

In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs[1]. A "harm reduction approach" recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug use, from reducing the sharing of injecting equipment, through to stopping injecting, substitution for heroin users and abstinence from illegal drugs. Most harm reduction interventions specifically aim to prevent blood-borne diseases (most particularly HIV and hepatitis infections) and other drug-related harm, including overdose and drug related death. All drug treatment services, residential or community based, should provide a distinct harm reduction element to reduce the spread of blood borne viruses and risk of drug-related deaths in the treatment they provide. Specific harm reduction interventions to reduce the spread of blood-borne viruses and reduce overdose include:

- Needle exchange services i.e. the provision and disposal of needles and syringes and other clean injecting equipment (e.g. spoons, filters, citric acid) in a variety of settings.
- Advice and support on safer injection and reducing injecting and reducing initiation of others into injecting.
- Advice and information to prevent transmission of BBVs (particularly hepatitis A, B and C and HIV) and other drug use-related infections.
- Hepatitis B vaccination.
- Access to testing and treatment for hepatitis B, C and HIV infection.
- Counselling relating to HIV testing (pre and post test).
- Advice and support on preventing risk of overdose.
- Risk assessment and referral to other treatment services.

Harm reduction interventions such as needle exchange, advice and information on safer injecting, reducing injecting and preventing overdose should also be available as open-access services in each local area. Needle exchange services often have contact with problematic drug users who are not in touch with structured drug treatment services. Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or

1 UK Harm Reduction Alliance website at http://www.ukhra.org

service level agreements and also into structured drug treatment according to an individual client's needs (National Treatment Agency for Substance Misuse, 2005).

A status paper on prisons and public health related to drugs and harm reduction defined harm reduction measures in prisons as:

> A concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health. (WHO Regional Office for Europe, 2005)

Harm reduction acknowledges that many drug users cannot totally abstain from using drugs in the short term and aims to help them reduce the potential harm from drug use. In addition, the definition WHO adopted acknowledges the negative health effects imprisonment can have, which include the impact on mental health, the risk of suicide and self-harm and the need to reduce the risk of drug overdose on release. It also emphasises the more general harm resulting from inappropriate imprisonment of people requiring facilities unavailable in prison, especially in those which are overcrowded.

Problematic drug use

Problematic drug use can be defined as the use of substances 'which involves dependency, regular excessive use or use which creates serious health risks' (Edmunds et al., 1998). It is also frequently linked to offending, be it a direct cause such as theft to fund drug use or a contributory factor such as violent crime. In most countries problematic use was understood as distinct from recreational or experimental use, in that it often led to harmful consequences, and it was also referred to as substance misuse and addiction.

2.5 Procedures and ethical issues

The participants involved in the study included staff and focus groups of prisoners in the sample prisons. Interviews were also carried out with officials from the national prison administration in each country and other governmental organisations and with NGOs. The sample prisons were chosen with the assistance of country co-ordinators and staff in the national prison administrations. Participants from the sample prisons included the prison/ institution director or deputy, head of security, person(s) responsible for drug treatment strategies including harm reduction, head of health care, person

responsible for through care liaison with the community and other specialist staff (e.g. psychologists, psychiatrists, social workers and educators). Some of the roles within both the national prison administration and the sample institutions were the responsibility of one person, such as drug treatment and harm reduction, which could also come under the remit of healthcare personnel. Prisoners were generally interviewed in focus groups of 8 to 10, some of whom were based on drug free wings and undergoing treatment, and others on general wings/sections.

It was necessary to use translators during the visits to most of the sample countries (with the exception of Germany and Austria), the majority of whom were not working in the field of criminal justice, which on the whole presented an advantage, as:

> During the research as they were able to explore the meanings of terms used in detail during the interviews adding to the clarity of the data collected and reducing the possibility of taken-for-granted culturally-specific understandings'. (MacDonald, 2005)

The settings in which the interviews with prison staff and prisoners took place differed, depending on what was available. In most cases, a room normally used by prisoners for classes was used, and it was important to gain assurance that the venues were suitable, and that prison officers remained outside the room. During the focus groups it was important for the researchers to ensure the key themes of the interview checklist were covered, whilst also allowing prisoners to discuss new insights and issues that they identified. It was also important to ensure all participants in the focus group were given an opportunity to express their views if they wished and that the group discussion was not dominated by one or two participants.

The interview checklist contained questions relating to the relevant areas of prison policy and practice. This was used with prison staff and staff from the national prison administrations, which was adapted to suit the different roles within the prison. Different checklists were used for the prisoner focus groups and interviews with NGO staff (see Appendix 1).

The staff interviews (with the National Prison Administration, sample institutions and NGOs) lasted approximately 45 minutes to one hour, and were conducted on a one to one basis, with some exceptions, due to time constraints. The focus groups lasted approximately 90 minutes.

Conducting research in prison can be problematic due the sensitive nature of the issues under discussion, such as revealing incidences of drug use and sexual activity which can be treated as 'disciplinary behaviour'. In addition, the lack of official recognition of these behaviours occurring makes it difficult to illicit meaningful responses. Therefore it is important for the research to be underpinned by clear ethical guidelines for the protection of both the participants and the researcher. This research followed the ethical guidelines provided by the British Sociological Association[2], which included informing all participants that their responses would be treated confidentially, and that they were free to withdraw their participation at any time.

2.6 Methodological issues arising from the fieldwork

- Despite knowing before hand that it was necessary to hold the focus groups without prison security being present this had to be renegotiated in some prisons and a compromise reached where the guard sat outside the room.
- Due to time constraints individual interviews with prison staff was not always possible rather a group of staff were interviewed together, which could be problematic if the staff present had very different roles and priorities.
- Some prisoners in the focus groups had not previously been drug users and as such had limited knowledge of drug use although they were aware of what harm reduction tools were.
- On one occasion, prisoners had been kept waiting from 8am in one room until the researcher arrived at 3.30 pm – they had not even had their lunch – this caused some initial hostility to the researcher.
- Problems arose if prisoners were not fully informed by the prison staff, of the purpose of the research, as this led to confusion and in some cases hostility towards the researcher.
- There were some cases were prisoners reported that they were told to attend and were not given a choice, which did not comply with the ethical guidelines of the project.
- It was not possible to visit prisons in Spain due to lack of permission and time constraints, so the fieldwork was limited to interviews with prison administration staff.

2 See: www.britsoc.co.uk/equality/63.htm

- The questionnaire received from Latvia provided very little information on current practice with regards to harm reduction services, therefore it was not possible to include the data gathered from this.

Chapter 3

Profiles of the prisons and NGOs visited – trends and responses to drug use in prisons in the sample countries

This section presents data on the prevalence of drug use in each country, along with details of the overall prison population and the specific institutions and NGOs visited. It also gives an overview of the general situation with regards to imprisonment rates and drug related offending in the EU, with reference to the variations between new and established member states.

3.1 Prison population rate

When comparing the prison population rate per 100,000 of the general population, research data has shown that in 6 of the 9 countries visited, there were higher rates of imprisonment compared to the current EU average of 121 per 100,000. For example, in Estonia the rate is 337.9, in Lithuania, 227.1, Poland, 207.8, Romania, 184.6 and Bulgaria, 140.2. These figures demonstrate high levels among new EU member states, which for many is a legacy of Soviet rule, and add to the difficulties for these countries who are in a transition towards more modern prison administration (Council of Europe, 2004). This also affects the organisation of prison health care, and the general conditions for both staff and prisoners (MacDonald, 2005). With regards to female prisoners, the majority of countries have imprisonment rates below the EU average of 5%, with the exception of Spain (7.6%), Austria (5.8%) and Germany (5%) (Council of Europe, 2004).

3.2 Sentenced prisoners by main offence (drug offences)

The Council of Europe statistics[1] demonstrate a wide variation across the EU in the prevalence of drug related offenders sentenced to prison. Italy (35.4%)

1 Council of Europe, SPACE, 2004; modified by WIAD, 2007.

and Spain (21,5%) are above the EU-average of 18.5%, whereas Germany has a lower rate of 14.6%, and this is significantly lower among new member states, such as Lithuania (4.8%) and Estonia (4.4%). Currently, there is no data available from Bulgaria, Austria and Poland, although statistics do reveal that a high percentage of sentenced prisoners are actually drug users, sentenced for other offences. At the moment it is not clear whether or not the assessment and monitoring system is less developed in the new EU member states or if the number of prisoners sentenced for drug offences really is significantly lower. Such caution is also necessary when looking at the extent of drug use in prisons, particularly for injecting drug users, which is frequently not acknowledged by prison administrations (MacDonald, 2005; Stöver, 2002).

3.3 Austria

3.3.1 General Overview

The Prison Administration in Austria is managed under the Ministry of Justice. The overall prison population of Austria is 8766, which constitutes a rate of 105 per 100,000 of the national population. The official capacity of the prison system is 8289, therefore the current occupancy level is 107.2%. Among the 28 establishments, 22.6% are pre-trial detainees, 5.3% of prisoners are female and 2.3% are classed as juveniles. The proportion of foreign prisoners is 45.1% (World Prison Brief, 2007). It is estimated that there are approximately 2000 problematic drug users in prison in Austria. For example, the prison at Josefstadt in Vienna, one of the largest prisons in the country, there is space for 990 prisoners and 40% are believed to have 'addiction diseases', with 30% using more than one drug and 10% using alcohol (Kahl, 2007). In addition there are concerns that the risk of prisoners contracting new infections during the prison term is increased due to shared use of injecting equipment, tattoos and unsafe sex (Grüner Kreis, 2006b; EMCDDA, 2006). Whereas syringe exchange is not yet available in Austrian prisons, substitution treatment can be continued or started in prison, and support is also provided at the time of release.

The basic training for all prison staff lasts 14–18 months, and is supplemented by additional courses once they start working in the prison. Much of the training about drug use and associated risks is covered. Staff reported that medical checks of drug users usually take place during time spent in

remand prison (e.g. Josefstadt (Vienna) or Eisenstadt), which lasts from few months up to one year. They will also start treatment and other therapies at this stage, however, an important element of addressing drug use is to offer such treatment as part of a community sentence, i.e. therapy instead of punishment. The "Schweizerhaus Hadersdorf" are responsible for providing this, as they have a range of treatment options and therapy to offer, which includes substitution treatment. Generally, the principle of therapy instead of punishment continues to be an important component of all drug strategies and plans in Austria, and they are implemented through a range of services and organisations (ÖBIG 2002a).

3.3.2 Prisons and NGOs visited

The prisons visited in Austria were in Hirtenberg and Stein. The prison of Hirtenberg, some 30 m southwest of Vienna, is for adult male sentenced prisoners (averaging 3–5 year sentences) and was at 10% over its capacity at the time of the visit (August/September 2006), with 374 prisoners. The prison drug service became well-known when the first drug free-zone was established at Hirtenberg in 1995 (Steinacher, 2000; Bundesministerium fűr Justiz, 2002). The prison of Stein ("Justizanstalt Stein") is a high security prison for adult male sentenced prisoners located in the province of Lower Austria, not far from the Czech border, and has a total capacity of 730 places.

In Hirtenberg prison, staff reported that drug use is increasing, even though the detection of drugs and injection equipment is not, indicating that there may be different patterns of use among prisoners. There are 80–85 places in the drug free unit for both former drug users and for those who don't want any contact with drugs, drug smuggling and drug culture. This may be something they have done in the past and no longer wish to engage in, or something they have had no contact with and do not wish to risk such contact during their sentence. The cells hold 3 prisoners on average and 30–35% are foreign prisoners – this is a more vulnerable group as there is very little information which is translated for them, they have to instead rely on fellow prisoners. Currently, there is no substitution treatment provided in the prison.

Throughout the prison system, incidences of self harm and suicide are decreasing, which the prison governor at Hirtenberg attributes to the introduction of televisions and computers (with Play Station) for prisoners. The prison staff at Hirtenberg reported that there had been no sexual offences in

recent years. At both prisons, condoms are available and freely accessible to prisoners, although so far, demand has not been high. In the prison of Leoben there is a trial going on with accompanied visits (conjugal visits) from partners and family for those who are in prison for a long time.

Within prisons in Austria, tattoos are not permitted, even though in the community, among the general public, they are more acceptable. Tattooing is seen as a punishable offence as it is regarded as self harm, however, the extent of tattooing is not closely monitored. Generally, healthcare staff at both prisons visited reported that they become aware of tattoos if prisoners report health problems as a result of getting one or during general medical exams. In addition the prison directors and security staff are aware of the need to control this, due to the health risks of prisoners sharing tattooing equipment.

3.4 Bulgaria

3.4.1 General Overview

The Central Prison Administration is managed under the Ministry of Justice, and currently the prison population is 11,436, which represents an occupancy level of 130.9% (the capacity of the 13 establishments throughout Bulgaria is 8738). Of the total prison population, 18.2% are in pre-trial detention, 3.4% are female prisoners, 1.3% are classed as juveniles and 2.2% are foreign prisoners (World Prison Brief, 2007).

According to the available data the number of the addicted prisoners tripled in the last three years – in 2003 in prisons 565 addicted persons were registered, in 2005 their number was 1071, and during the last count at the beginning of 2006, 1728 drug dependent persons were registered. The majority use cannabis (487 prisoners), with 313 prisoners using cocaine, 425 using heroin, and 216 inject their drug. At the start of 2006, 6% of prisoners were registered as addicted to drugs which contributed to the development of offering methadone programmes within prisons. In the spring of 2006 a national representative study was carried out, “Drug Use among Prisoners in Bulgaria: General Status and Trends”, financed by the National Drug Strategy 2003–2008 and with the financial support of the EMCDDA. The specific problem areas were examined, for example the level and characteristics of drug use, history of use, potential use, risk behaviour, need for treatment, level of awareness, illegal traffic of substitutes of drugs, behavioural and

psychological problems of adaptation and expected problems after release of prison. This was conducted in 13 prisons covering more than the half of the prisoners in 9 Bulgarian cities (N= 1,257) and it showed that 37.1 % of the prisoners used any type of drug at least once in their lifetime (23.4 % – heroin, 22.5 % – cocaine, 19.4 % – amphetamines) and that 9.4 % have used drugs in the last 30 days.

All problematic drug users sentenced to prison have to undergo a medical and psychiatric examination, as part of a general risk assessment and to determine a plan for the duration of their sentence. Such plans can include where they are placed in the prison, work opportunities and participation in training, educational, and correctional programmes. One example of such programmes is the 12-step-programme for drug dependent prisoners, and there are also short term programmes in development.

During 2005, 15 crisis interventions with drug users in prisons were implemented, in which 101 drug dependent persons were detoxified, and in several prisons 14 psychotherapeutic groups worked with over 200 participants[2]. The therapeutic and rehabilitation programmes for drug dependent prisoners form an integral part of community based probation sentences, which aim to divert users from custodial sentences and reduce re-offending after release.

3.4.2 Prisons and NGOs visited

In Bulgaria, Varna prison was visited primarily due to the high number of programmes and rehabilitation services available to prisoners. The official capacity of the main prison in Varna is 350 and at the time of the visit (April 2006), there were 600 prisoners, meaning the prison is overcrowded (by approximately 70 per cent). However, the overcrowding and conditions are considered to be improving gradually. This prison has a number of other smaller prisons under its general management: a transitional prison, an open prison (for first time offenders) and a prison farm. There are 889 prisoners in total under the management of the director of Varna Prison.

Since 2003, when this prison was previously visited (MacDonald, 2005), there have been some changes. The prison has received more funding and now has gas and the roof has been repaired so the conditions of the cells have improved and are no longer damp. In 2004/5, new legislation allowed

2 Source: General Directorate "implementation of Punishments".

prisoners to work outside of the prison estate, for those sentenced in the "open" and "transitionary" prisons. In addition, employment in the surrounding area has risen, which is reflected in the increased opportunities for prisoners. Currently, there is a shortage in skilled labourers for ship building and the prison is in discussions to develop training for this area for prisoners, so that on release, they will have the opportunity to work in this industry. The rules for the organisation of prisons are also in the process of change, for example, regional administrations will be created so that in Varna, the prison, transitory houses, remand centres and probation will be under one county administrative structure. The central prison administration have hired 500 more staff for the probation service but there is still a shortage of security staff, on a national scale.

The Varna Association of NGOs for Drug Prevention was also visited – they work both in the community and also directly with the prison in Varna. Previously they have provided training for prison staff and will shortly start a harm reduction programme.

3.5 Estonia

3.5.1 General Overview

The Department of Prisons is governed by the Ministry of Justice in Estonia, and is responsible for 7 establishments, with a total of 4463 prisoners. This represents an occupancy level of 102.2%, as the official capacity of the prison system is 4,366. 23.1% are pre-trial prisoners, with 3.9% female prisoners, 2% are juveniles and 36.4% are foreign prisoners (World Prison Brief, 2007).

In 2005 the Ministry of Justice carried out a survey on drugs in prison (Kikas et al., 2006) with the purpose to identify the attitude and knowledge of prisoners and prison officers about narcotic substances, map drug use problems to plan long-term activities in the field of prevention of drug use in prisons and make suggestions for the development of appropriate rehabilitation programmes. The target group of the survey were adult male detainees from the colony-type male prison having experienced problems and/or health risks caused by drug use and related risk behaviour. Murru Prison is the biggest colony-type prison in Estonia where 50% of all convicted prisoners are serving their sentences.

In addition to prisoners, the respondents were selected from institutions closely related to the target group and responsible for the provision of relevant information, such as non-profit associations, prison officers and the police.

The findings of the survey indicate that both prisoners and staff members were uncertain about the proportion of prisoners not using substances. According to the majority of respondents (varying responses of detainees and staff) this was estimated as between 15–50%. 'Group pressure' and 'lack of activities' were two major factors which might have played a role in starting substance use in prison along with stress, and the 'need for identity'. The most widely used drugs in prison were products made from cannabis and amphetamines, followed by heroin and fentanyl, with the main routes of administration of cannabis and amphetamines being smoking and injecting, respectively. However, some respondents said that amphetamines had also mostly been swallowed or sniffed. All respondents shared the view that heroin and fentanyl had mostly been injected (EMCDDA, 2006).

3.5.2 Prisons and NGOs visited

In Estonia, the prisons visited were Tartu, Tallinn and Harku. Tartu is a modern prison for pre-trial and sentenced men and a small number of pre-trial women. It is a closed prison consisting of double cells rather than a camp style prison. The intention in this prison was to have single cell occupancy, therefore the official capacity is 478, however currently there are 930 prisoners, with 2 per cell. There is single cell occupancy in the psychiatric ward. From information received from prisoners at reception to the prison 70 per cent had used drugs prior to starting their sentence.

Harku is a women's prison near Tallinn, which according to the director has not as yet reached its' maximum capacity. The women are accommodated in rooms of up to 16 but normally there are 10 per room. Approximately 70% of the prisoners are Russian speaking, with 30% being Estonian speakers. According to the Director of the prison about 50% of the women used drugs outside of prison, but use in prison is reported to be relatively low. This is attributed to the prisoners having less money to buy drugs and, due to security measures, they are unable to buy drugs within the prison. Access to drugs normally comes from outside contacts.

Tallinn Prison holds male pre-sentenced and sentenced prisoners and also has a small section for (approximately 45) women. At the time of the visit

(January 2006), there were 1104 prisoners in the main prison and 54 in the prison hospital (705 were pre-sentenced and 320 were sentenced prisoners). The prison is overcrowded, as the official capacity of the prison is 650. The prison director reported that approximately 10% of the prisoners were problematic drug users, and the other 90% had probably tried drugs.

In Estonia the NGO CONVICTUS supports HIV positive people and those with a drug addiction; they offer self-help, prevention and rehabilitation centres. CONVICTUS started in 2002 and now has 25 employees of whom 50% are ex clients. They have four main projects financed by the global fund in the main, with 10% from SOROS and 7% from the government. They provide support groups (for prisoners, ex-prisoners and injecting drug users with HIV), needle exchange and counselling services. The government in Estonia now acknowledges them as an important part of the rehabilitation of prisoners, therefore although the current funding ends in 2007, state funding will take over until 2015. They are the only NGO who are constantly in the prisons and they have become an integral part of social work in prisons.

3.6 Germany

3.6.1 General Overview

The Ministry of Justice oversees the management of the Prison and Probation Service in Germany, and the current prison population is 76,629, which represents a capacity of 95.8%. Among the 195 establishments in Germany, 17.4% are on pre-trial detention, 5.3% are female prisoners, 4.5% are juveniles and 28.2% are foreign prisoners (World Prison Brief, 2007). There is a higher prevalence of consumption of psychotropic substances and of substance-related disorders among prisoners compared to the community. Most of those who are incarcerated continue to consume psychotropic substances during their sentence, and the total number of those convicted for violations of the Narcotic Drugs Act was at 9,277 in 2005 (2004: 9,221). This equates to 14.6% of all detainees, and 15.4% for adult males and 20.1% for adult female prisoners. Among juvenile sentenced prisoners the figures were at 7.3% and 10.2% respectively.

The number of those detained for drug-related offences has remained stable from 2004 to 2005. However, the proportion of these offences in all detainees slightly increased from 2003 to 2005. Although women accounted for only 6% of this group, the extent of drug-related offences among female

detainees has increased more compared to such offences among male prisoners. The number of sentences imposed for juvenile offenders and the proportion of drug-related crimes in these sentences have been declining since 2003.

Substitution is prison in subject to different regional regulations and is patchy and does not cover all 16 Länder (regions). The continuation of substitution therapy is also not available in all Länder and this depends on the prison regulations and the prison doctor's assessment of such need. Currently, only a few Länder offer substitution treatment in prison across the board and programs are generally limited to 3–6 months (Pollähne/Stöver, 2005; Stöver 2007).

Focal areas of addiction work in prisons are, apart from prevention, mainly motivation to undergo withdrawal treatment, referral to inpatient withdrawal facilities or after care (Hessisches Sozialministerium, 2006).

The Narcotic Drugs Act (BtMG) allows for the suspension of proceedings in cases of minor guilt or lack of public interest in prosecution (§31a BtMG). This applies mainly to consumption-related offences, in particular when they occur for the first time and third parties are not involved. These regulations are subject to different regional application as shown by a study carried out by Schäfer/Paoli (2006). Furthermore, it is possible to defer prison sentences to provide drug addicts with a chance to undergo therapy ('therapy instead of punishment', §35BtMG).

3.6.2 Prisons and NGOs visited

In Germany, the prisons visited were a women's prison in Vechta, 40 km south of Oldenburg in the north west of Germany and a closed men's prison in Groß-Hesepe, between Lingen and Meppen in Lower-Saxony (near the Dutch border), which is administered by the larger prison in Lingen (some 25 km from Groß-Hesepe). Vechta prison holds approximately 195 prisoners and is the only women's prison in Lower-Saxony (together with a department in Hildesheim). The prison accommodates both sentenced and pre-trial prisoners, and the reported proportion of drug users is estimated to be more than 50%. Groß-Hesepe prison also has both remand and sentenced prisoners, with 350 sentenced male prisoners. The proportion of drug users is also reported to be considerably at high levels, with approximately 70–80% prisoners having a drug problem (with hard drugs). Both prisons became well known when the first needle-exchange projects were introduced in 1996 and

subsequently abolished in 2002 (see Chapter 4 for more details on resistance to needle exchange programmes).

3.7 Italy

3.7.1 General Overview

In Italy, the Department of Prison Administration is responsible for 225 establishments, and is governed under the Ministry of Justice. The total prison population is 39,348, of which 57.1 % are on pre-trial, 4.3% are female, 0.7% are juvenile prisoners and foreign prisoners constitute 33.9% of the total prison population. The official capacity of the prison system is 42,959, therefore the current occupancy level is at 91.5% (World Prison Brief, 2007). In 2005 89,887 individuals entered prison, of which 25,541 were registered as addicts. A study by the Department of Penitentiary Administration showed that among addicted prisoners, 60% were affected by infectious diseases (4% of the sample group were women and 31% were foreign nationals). Among the prisoners in the study, 17% of the subjects were considered to have a history of opiate abuse, 21% used cocaine, and less than 1% used benzodiazepines or alcohol, while 61% were listed as being multiple users (in 65% of cases with heroin and cocaine).

3.7.2 Prisons and NGOs visited

In Italy, the three prisons visited were in Padova and Milan. In Padova Circondiarle prison, 60% of the prison population are classified as problematic drug users. There is generally considered to be sufficient drug treatment available in the prison but staff have reported a need for more resources and services to cope with increasing demand. Overcrowding in the prison is very high at about 200% at the time of the visit (February 2006) with 210 prisoners – the capacity of the prison 98. At the moment there are 2 or 3 prisoners in cells designed for one prisoner, and up to 5 in cells designed for two prisoners. The overcrowding is attributed to high numbers of migrant prisoners who are drug users, but also due to the lack of alternative sanctions for problematic drug users, i.e. community sentences, which could be managed by Ser.T[3].

3 Servizio Tossicodipendenze, an Italian drug treatment centre which is part of the National Health Service.

6% of therapeutic programmes allocated by the Ser.T in 2005 were carried out within the penitentiary system. As with Ser.T, the most representative programmes are methadone treatments, roughly 83% of subjects undergo therapy with non-substitutive drugs (around 16% in prison and 14% in the Ser.T) and with symptomatic therapy (clonidine at 1% in both prison and the Ser.T). Antagonist treatments are almost entirely absent from the penitentiary system (naltrexone 0.1% as opposed to nearly 2% under the Ser.T). The differences in typology of methadone treatments sponsored by prisons and by the Ser.T can be determined by examining their duration. In the Ser.T, long-term methadone treatment represents nearly 56% of integrated therapy programmes, while long-term programmes within penitentiary institutions are at only 24%, favouring short and medium-term therapy plans that make up 31% and 28% of programmes, respectively. In the Ser.T such programmes are mostly outpatient and are at roughly 11% and 17%, respectively[4].

San Vittore Prison in Milan was also reported to be overcrowded at the time of the visit, as two sections of the prison were closed for refurbishment. The official capacity of the prison is 1000 for male prisoners and 100 for female prisoners and there were 1420 male prisoners 135 female prisoners. In this prison there are about 200–300 problematic drug users and about 60% of those with drug problems are foreigners. Many of the foreign prisoners (about 50–60%) are facing problems with accessing drug treatment services, as they do not have permission to stay in Italy, therefore Ser.T cannot help them.

Bolatti Prison in Milan is a relatively new prison and foreign prisoners make up about 40% of the prison population. There are diverse cultures amongst the foreign prisoners and this causes language problems both between the prisoners and with the guards. The prison used to have cultural mediators and staff reported that they want to start this programme again after they decide how to use them to their best advantage rather than just as translators.

The Ser.T in Padova was also visited. Since 2000, legislation stated that prison drug treatment would be under the control of Ser.T and they now work directly within prisons. The Ser.T in Padova works with two prisons, treating approximately 1200 prisoners, of which 30% are problematic drug users (both remand and sentenced prisoners). However, in the remand prison

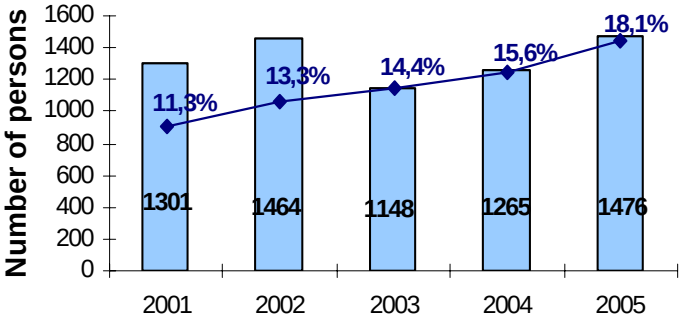
4 See Reitox Focal Point Report, 2006.

85% of the prisoners are migrants and more than half of them are problematic drug users, compared to the sentenced prison where 30% of the prisoners are problematic drug users and the migrants are in the minority.

3.8 Lithuania

3.8.1 General Overview

In Lithuania, the Prison Department, managed under the Ministry of Justice is responsible for a total of 7983 prisoners in 15 establishments. The official capacity of the prison system is 9444 and therefore the current occupancy rate is 84.6%. 13.6% of the total prison population are pre-trial detainees, 3.3% are female prisoners, 1.8% are juveniles and 0.8% are foreign prisoners (World Prison Brief, 2007). In 2005 18.1% (1476 prisoners out of 8155) were reported to be dependent on drugs or psychotropic substances[5]. This represents an increase since 2001, when the rate was 11.3% (1301 persons) in 2001, despite measures of supply reduction (more controls on delivered parcels, introscopes, trained dogs, increased level of qualification and knowledge of personnel, technical security facilities, etc.) which reduced external availability of drugs and psychotropic substances.



Source: the Drug Control Department under the Government of the Republic of Lithuania and the Department of Prisons under the Government of the Republic of Lithuania

Figure 1: Number of imprisoned persons dependent on drugs and psychotropic substances and their share (percent) of all imprisoned persons, 2001–2005

5 Information Source: the Department of Prisons under the Ministry of Justice.

According to the National Focal Point Lithuania[6] data analysis of the dispensary records of drug users identified the main drug used in prison are opioids (42%), however, a significant decrease of this drug use is observed. In 2005, the number of stimulant users increased (amphetamine, ecstasy), which is attributed to a number of reasons, e.g. a low acquisition price, availability in illicit trafficking outside prisons, compactness (tablets, powder) and fewer risks of both detection by prison staff and of contracting infectious diseases. In contrast, during 2005, imprisoned persons rarely used cannabis (2.6%), cocaine (0.2%) or hallucinogens (0.2%). According to data of the Prisons Department under the Ministry of Justice and the Lithuanian AIDS Centre at the end of 2005, 254 prisoners were HIV positive which included 59 new registered cases, 12 acute HBV patients, 7 acute HCV patients and the biggest number of the above individuals were infected injecting drugs and psychotropic substances.

In 2005, the Lithuanian AIDS Centre conducted a survey of HIV infected individuals released from prisons aiming at analysis of their social problems, needs and behaviour, with focus on problem solutions, selected problem solutions, collection of data concerning behaviour of this risk group, identification of the main HIV infection factors, identification of behaviour models for this risk group and social behaviour to be changed by application of targeted intervention. The majority of the surveyed individuals after their release from imprisonment continued to inject drugs, mainly opiates (63%), opiates together with tranquillizers (37%) and nearly half of them (46%) reported that they shared drug injecting tools. However, encouragingly, the study also showed that 50% of the surveyed used new syringes and needles obtained in the Lithuanian AIDS Centre's harm reduction unit.

In addition, among the respondents, unsafe sexual behaviour prevailed, such as condom use on rare occasions and frequent change of incidental sexual partners and 70% of the respondents pointed out they faced problems in life due to their imprisonment and HIV infection. The social services needs of respondents were identified as related to their personal documents, being out of work and without any profession, without a permanent place of residence, disrupted social relations with kinship or absence thereof.

6 Annual Report, 2006.

3.8.2 Prisons and NGOs visited

In Lithuania, Vilnius Correction House (number 2) and Panavesky prison were visited. Vilnius Correction House is a specific type of prison found in Lithuania which has a less strict security regime, compared to other prisons which are referred to as 'jails'. Its' current capacity is 1000 and at the time of the visit, it had 631 prisoners. There was a decrease in the prison population after legal reforms in 2003 which meant fewer crimes were punished by prison sentences and there was a move towards using supervised community sentences. The majority of prisoners have a sentence of 1–3 years, and are aged between 21–40 years old.

Panavesky Prison is a female prison, which includes an arrest house for those prisoners on sentences of 90 days or less. The capacity of the prison is 540, and currently there are 211 prisoners. It also has a mother and baby wing, where children can stay with their mothers up to 3 years old. The staff estimate that approximately 30% of the prisoners had a drug and/or alcohol problem prior to coming to the prison.

The Correctional Affairs Department were open to working with NGOs but currently there are not many NGOs that want to work with the prisons. Currently there are a few charities, like CARITAS working with prisoners. Recently, at Vilnius Correction House, they have started to work with an NGO called 'Space of Life', which is a rehab centre for drug addicts. They organise group therapy for prisoners (who want help) and provide social care after release. They are also working hard to be active participants in National Programme of Drug Prevention and Control and infectious disease prevention (including sexually transmitted diseases), on a national level and throughout the whole prison system. A consultant from Alcoholics Anonymous works with Panvesky prison, to set up and run group meetings and also to contribute to pre-release courses.

3.9 Poland

3.9.1 General Overview

The Prison Department in Poland is managed by the Ministry of Justice, and it is responsible for a total of 86 prisons, 70 pre-trial prisons, 32 external units, 14 prison hospitals and two facilities for mothers with small children. A large proportion of Poland's prisons are old and face structural problems – 64.5% were constructed prior to 1914. This has implications for the provi-

sion of healthcare for many prisoners. In the Polish prison system home leave is an important part of the preparation for release, along with through-care services for those prisoners who need additional support after completing their sentence. In addition, in 2003, 3000 prisoners took part in training for 'active work search'. This training was organised by an NGO called Bureau of Social Initiatives that was financed by the PHARE programme (MacDonald, 2005).

According to the Polish National Focal Point[7] in 2005 prison system facilities provided:

- 12 specialist drug-free therapeutic programmes,
- 3 substitution treatment programmes (run in 5 facilities),
- 56 addiction prevention programmes,
- Non-supervised visits.

In 2005 the number of prisoners in drug treatment serving sentences in penal institutions and remand centres was 1325, compared to 1157 in 2004 (increase of 12.7%). Still it is difficult to talk of the increase in the availability of benefits since the number of prisoners requiring drug treatment is rising much faster. In 2005 the time of waiting for the admission to a drug treatment ward for prisoners addicted to narcotic drugs and psychotropic substances lengthened by another 2 months (from 11 months in 2004 to 13 months in 2005)[8]. The existing system of drug treatment for prisoners addicted to psychoactive substances still remains inadequate in relation to the real needs. Prisoners can wait for a vacancy in a therapeutic ward for several months and some of them are released from prison without proper drug therapy.[9]

The key problem of substitution treatments is the difficulty in continuing therapy after release, which results in very few prisoners taking up such treatment during their sentence and illustrates the need for substitution treatment within the prison system to be coordinated with the one in the community. The development of substitution treatment in 2005 was co-financed by local governments in 4 regions (out of 16 existing in Poland, Dol-

7 Polish National Focal Point. Report to the EMCDDA, 2006.

8 Data provided by the Bureau of Health Service at the Central Management Board of Prison Service.

9 Polish National Focal Point. Report to the EMCDDA, 2006 (p. 87ff).

nośląskie, Kujawsko-pomorskie, Lódzkie and Zachodniopomorskie (NBDP unpublished report, 2006a, p. 104).

3.9.2 Prisons and NGOs visited

The prison system in Poland is managed by the Central Board of the Prison Department, under the Ministry of Justice. There are fifteen regional inspectorates, which responsible to the Central Board, and they manage 86 prisons, 70 pre-trial prisons, 32 external units, 14 prison hospitals and two facilities for mothers with small children. Many of Poland's prisons are old establishments facing continuing structural problems, which impacts on the health-care services for prisoners. The majority (64.5%) were built prior to 1914, with a small number designated as historical monuments built in the 13th–14th century. Of those built after 1914, six were converted from prisoner of war camps, leaving just 23.3% of establishments being built after World War II. The prison population in Poland is 91,331 (at 31.3.2007), including pre-trial detainees/remand prisoners. The number of prisoners has risen markedly in recent years. During the 1990s, figures were stable at about 65,000, but in 2000–02, this rose from 70,000 to current levels (World Prison Brief, 2007).

The NGOs visited was Monar. Monar is a non-governmental, non-political Association, which was officially registered in 1981 and operates all over Poland. An agreement between Monar and the Central Board of the Prison Department has been signed as of the 4th of December 2003. This allowed a more centralised and structured prevention and awareness training and permission to go into all prisons.

3.10 Romania

3.10.1 General Overview

The National Administration of Penitentiaries reports to the Ministry of Justice, and oversees the management of 33,368 prisoners in 45 establishments, which currently have an occupancy rate of 90.4%. Pre-trial detainees constitute 14.2% of the total prison population, and 4.7% are female prisoners, 2.1% are juvenile prisoners and 0.7% are foreign prisoners (World Prison Brief, 2007).

According to the data provided by the National Prison Administration, out of 37,600 prisoners, 2402 self-declared as drug users in 2005 (93.8% men and

149 women 6.2%). The data presented by the Romanian National Focal Point[10] below refer only to the prisoners who self-reported as drug users or former users upon entry into penitentiary. The number of self-declared drug users upon incarceration, increased from 1065 (3%) in 2001 to 2402 (7%) in 2005. Most of the self declared former drug users were aged 20–24 (62.23%). Heroin users accounted for more than 80% of the total self-declared drug users, with a slight increase from 86.2% in 2004 to 90% in 2005.

Building on the role of the probation services, a collaboration protocol with the Justice Ministry Probation Directorate regulating probation in case of drug users has been developed, in order to provide them with integrated medical, psychological and social care by correlating the responsibilities of the IACC and the probation services. Additionally, a joint order of the Minister of Justice, Minister of Health and Minister of Administration and Interior[11] was formulated on the means to carry out medical, psychological and social care for prisoners. In 2005, several activities were carried out within the National Penitentiary Administration in order to provide treatment for drug using prisoners. For example, these included developing multidisciplinary assistance teams for drug users of physicians, psychologists, social workers, educators, surveillance staff, in order to implement prevention and therapeutic programs; formulating a strategy for the implementation of prevention and therapeutic programs for drug using prisoners, and creating a central commission for addictions including decision-makers and practitioners within the central administration and several penitentiaries[12].

3.10.2 Prisons and NGOs visited

In Romania, Colibash Prison Hospital, Colibash prison and Giurgiu Prison were visited. Colibash prison hospital is on the same site as the prison but the two organisations are run separately. The staff at Colibash prison hospital complete a profile of prisoners, and also offer HIV testing, pre and post test counselling and hepatitis B and C testing. After this an education programme starts for drug users about how to reduce the harms associated with injecting drug use, such as sharing needles. There is a high turnover of prisoners, so

10 Romania National Focal Point. Annual Report to the EMCDDA, 2006.

11 The joint order was approved May 2006, issued by Ministry of Public Health, Ministry of Justice and Ministry of Administration and Interior, OG: 471/May 31, 2006.

12 See Reitox Focal Point Report, 2006.

the staff have limited time to spend with each prisoner, and often the services is limited to basic healthcare and providing prisoners with information.

Colibash prison, which is on the same site as the hospital was also visited. This is a high security prison with 1300 prisoners and the prison is usually 96–97% occupied. The director said that he would still like to have a smaller number of prisoners so that the staff could work better to help the re-integration of prisoners. The prison also has separate wings for juvenile and female pre-sentenced prisoners.

Giurgiu Prison is a high security sentenced prison with 1500 prisoners on average (the official capacity is 1600) and this includes juveniles and female prisoners. At the time of the visit (July 2006), the prison was not overcrowded. The prison works with the Anti-Drugs Agency (ANA) representative based near the prison, who will soon begin to work directly with problematic drug users in the prison.

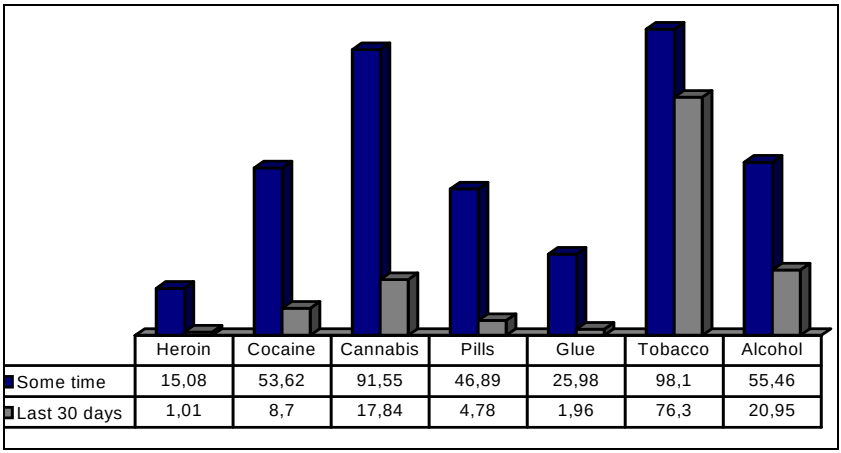
At Hospital Number 9, an NGO (ALIAD) was visited. They were formed to fight against problematic drug and alcohol use and with regards to harm reduction they have run a needle exchange project. This started in 2000 with funding for 2 years from SOROS and then the Global Fund, which is hoped to continue. They have an outreach team with paid workers, on 150 Euros a month – this is considered to be a low salary, but the staff are highly trained and skilled in implementing needle exchange services. Another initiative is a Methadone project with funding from the open society but they are not able to implement it due to the current situation about the control of methadone in Romania. ARAS (Romanian Association Against AIDS) is a national, non-governmental, apolitical and humanitarian organization. The key aim of ARAS is to stop the HIV/AIDS epidemic through the development of educational, informative, communication programmes and to offer social assistance services for people living with HIV/AIDS and their families.

3.11 Spain

3.11.1 General Overview

In Spain the Ministry of Interior governs the General Directorate of Prison Administration, which is responsible for the management of 65,170 prisoners in 77 establishments. The current occupancy rate is 133.7%. 23.6% of the total prison population are in pre-trial detention, and 8.2% are female prison-

ers. Juvenile prisoners constitute 2.3% (under 21 only, for those under 18, the rate is 0%) and 32% of the total prison population are foreign prisoners (World Prison Brief, 2007). The use of psychoactive substances in prisons is high; especially tobacco, alcohol and cannabis. In general, the drug consumption is higher among males, except for cocaine, solvents and tobacco, with similar intake levels (see following figure 3).

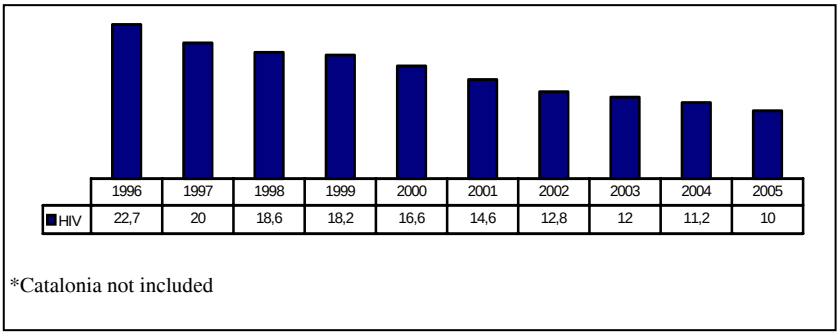


	Heroin	Cocaine	Cannabis	Pills	Glue	Tobacco	Alcohol
Some time	15,08	53,62	91,55	46,89	25,98	98,1	55,46
Last 30 days	1,01	8,7	17,84	4,78	1,96	76,3	20,95

SOURCE: GDNPD. "Analysis of the situation of protection and correction centres in the area of prevention" by the Centre for Social Promotion Studies (CEPs), 2004

Figure 2: Consumption prevalence of psychoactive substances in correction centres (2004)

The prevalence of HIV is 10.0% of the total prison population reported to the General Directorate of Penitentiary Institutions. The main form of HIV transmission continues to be the sharing of syringes for the intravenous injection of drugs in both sexes. According to the figure below the downward trend of the prevalence of HIV continues to occur in the penitentiary environment. The incidence of AIDS has gone down in both sexes and women continue presenting lower rates than men.



SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the General Directorate of Penitentiary Institutions

Figure 3: Evolution in the prevalence of HIV in prison population (Spain, 2001–2005(%)*

The prevalence of hepatitis C is 33.0% of the total prison population under the General Directorate of Penitentiary Institutions. According to Figure 4, the downward trend of the prevalence of HCV continues to occur in the penitentiary environment.

Data provided by the General Directorate of Penitentiary Institutions, shows that in recent years there has been a significant increase in the number of prisoners per year that have received treatment, with significant health, organisational and regulatory consequences in penitentiary centres, including abstinence-oriented treatments (detoxifications, drug-free units and therapeutic communities in prisons), substitution treatment and harm reduction. Detoxification programmes are offered to everyone who is diagnosed as a drug addict upon entering prison and who has not been entered in a methadone treatment programme. The number of prisoners included in regulated detoxification during 2005 was 1,868 drug addicts incarcerated in 56 penitentiary centres managed by the Central State Administration (Ministry of Interior, General Directorate of Penitentiary Institutions). Prevalence as of 31st December 2005 was determined to be 0.13% of the prison population and 7,188 prisoners were offered treatment in drug free units during 2005.

3.11.2 Prisons and NGOs visited

The institution visited for this research, Quatre Camins is in the region of Catalonia. Catalonia is also experiencing similar problems to the rest of

Spain, which are also affecting their rehabilitation programmes. In 2005 the Catalonia prison population was 8,305 of whom 2,765 were foreign prisoners. There are 77 prisons under the control of the central government and 11 in Catalonia, all of which are overcrowded (Gil-Robles, 2005). The overcrowding has resulted in many prisoners not being able to serve their sentence in prisons close to their families and made the process of rehabilitation difficult.

In the prison visited (Quatre Camins) both substitution treatment as well as a "Specialized Prison Care Programme for treating substance addiction for Prisoners in Catalonia" is being conducted[13]. Regarding the latter a cognitive-behavioural therapeutic community model in prison is being used. According to the responsible person F. Xaxier Roca Tutusaus[14] the intervention programme targets all prisoners in Catalonian prisons with a serious drug addiction problem. It aims to provide a drug-free environment and intensive treatment to help overcome an ongoing problem. The decree that created the programme (Regional Dept of the Presidency ["Generalitat"] Decree 184/1990 of 20 June) acknowledged that the drug addiction problem in penitentiaries was being handled in conjunction with other types of problems commonly afflicting subjects upon imprisonment. Nonetheless, a need was felt to prepare programmes that could broadly and explicitly address the drug addiction issue in the penitentiary environment in Catalonia more effectively than such rather non-specific strategies and measures.

Regarding the substitution treatment a manual has been elaborated by Spanish experts for the practical clinical treatment questions (Colom, 2005), which serves as practical guide for all relevant treatment issues.

13 Responsible: Secretaria de Servicios Penitenciarios, Rehabilitación y Justicia Juvenil. Departamento de Justicia. Penitentiary, Rehabilitation and Juvenile Justice Secretariat. Regional Department of Justice : Government organization.

14 See Programme Information: http://eddra.emcdda.europa.eu/pls/eddra/ShowQuest?Prog_ID=5317.

Chapter 4

Review of the literature

4.1 High risk behaviour in prisons

There are numerous studies which demonstrate that prisons and secure settings are facing increasing problems with drug use, sexual activity and other high risk behaviours which can have serious health consequences (MacDonald, 2005; Pallas et al., 1999; Polonsky et al., 1994; Lines et al., 2004; Stöver, 2002). In addition, problematic drug users are among the most vulnerable prisoners, and are over-represented within the prison population, often due to a growing trend towards the criminalization of drug use and possession and the use of custodial sentences for drug-related crime, throughout the EU (EMCDDA[1], 2003) especially among young people (Muncie, 2005). There is a clear need for prison systems throughout the EU to acknowledge that the use of drugs and sexual activity occurs within their institutions, in order to prevent prison health problems becoming public health problems (Ramsay, 2003). In addition, preventative measures will be in-effective, if national prison administrations continue to refuse to acknowledge or to deal with drug use, sexual activity, tattooing and the associated health risks.

4.1.1 Drug use in prison

There are various indicators of the extent of drug use in a prison, e.g. drug seizure quantities, discovery of needles/syringes, positive drugs tests among prisoners and official statistics of known and sentenced drug users[2]. Using such indicators alone may ultimately reflect only a part of the actual situation, and therefore provide an incomplete picture of the full extent of drug use, types of drugs used and routes of administration in prisons. Scientifically acquired data such as prevalence studies, while useful, may reflect the

1 European Monitoring Centre for Drugs and Drug Addiction.

2 According to the Federal Statistical Office for Germany 15% of all inmates are sentenced because of drug use/possession etc. Experts estimate that at least 20–30% of all inmates are drug users because they are often sentenced because of other delinquencies.

situation in no more than one single prison. Due to the changing nature of the population from one prison to another and from region to region within a country, these isolated cross-sectional studies cannot be taken as representative of the situation as a whole. In addition to illegal drugs, legal drugs (nicotine and tobacco, alcohol and prescribed pharmaceuticals) often contribute to the addiction and health problems of prisoners. Many prisoners have a long history of regular use of legal drugs and multiple drug use is widespread throughout the EU, particularly among young people (EMCDDA, 2003). Patterns of drug use vary considerably between different groups in the prison population, and between prisons in the same region, for example, juvenile prisons, women's prisons and prisons with a high percentage of foreign prisoners may have totally different drug use prevalence figures. Studies indicate that prison reception screening consistently underestimates drug and alcohol use and in many cases in which substance use is identified the quantities and numbers of different substances being used are underestimated (Lines et al., 2004).

However, despite the challenges in collecting data, it is generally accepted that drug use is a common activity in prisons around the world. According to UNAIDS;

> Whether the authorities admit it or not – and however much they try to repress it – drugs are introduced and consumed by inmates in many countries … Denying or ignoring these facts will not help solve the problem of the continuing spread of HIV. (UNAIDS, 1997, p. 3)

4.1.2 Nature and prevalence of drug use and related risks in prisons

Drawing a detailed picture of drug use in prisons is difficult in a particular country, and even more so across the EU. Qualitative studies are lacking, focussing particularly on drug use patterns in prison. Drugs used and patterns of drug use vary considerably between different groups in the prison population. For instance, drug use among women and juveniles differs significantly from that among men, with different levels and types of use and different motivations and behavioural consequences. Common factors are scarcity of drugs, extreme secrecy, and balck markets and trafficking within custodial settings.

Incidences of illegal drug use in prisons dates back to the 1970s, indicating that it is a longstanding phenomenon, and this also includes needle sharing. Generally, substances available outside prison can also be found inside pris-

ons, with the same regional variation in patterns of use, however, the quality of these drugs is often poor compared with that of drugs in the community. The type of institution also seems to have an impact on the extent and type of drug use, for example, studies have shown that drug use is more prevalent in large institutions, short-stay prisons, women's prisons and prisons close to a large urban centre. In addition, there seems to be less drug use in remand prisons because of the lack of organized trafficking networks. As in the wider community, cannabis is the most widely used illicit drug in prisons, with use of other drugs and injection of drugs at much lower rates. The frequency of use usually declines after imprisonment. This may be due to the reduced supply of drugs or it may reflect the ability of drug-using prisoners to reduce or stop drug use while in prison. Whilst imprisonment itself does not appear to motivate individuals to reduce or stop drug use, the lack of availability and resources to obtain drugs can have a significant impact, as can the fear of detection (WHO, 2007; Lines et al., 2004; Stöver, 2002).

The reasons given by prisoners for using drugs during their sentence include to relieve boredom, to cope with stress and crisis that occur such as sexual or physical violence (Marshall et al., 1999). Therefore prison itself can lead to prisoners continuing to engage and in some cases, starting to use drugs (EMCDDA, 2005). Studies have also highlighted incidences of prisoners switching to other drugs, which are easier to obtain, have stronger effect and are more difficult to detect in urine or blood. For example, the introduction of mandatory drug testing in prisons led prisoners to use opiates over cannabis which stays in the bodies' system for up to a month, whereas opiates can become undetectable within a couple of days (MacDonald/ Harvey, 1997; Edgar/O'Donell, 1998). In the countries of the European Union, for example, the number of prisoners who report ever having used illegal drugs is between 29% and 86%, with most studies reporting figures of 50% or greater. The number of prisoners actively using drugs during incarceration is between 16% and 54%. These EU studies indicate that figures for drug use are even higher among incarcerated women. In Canada, a 1995 survey by the Correctional Service of Canada found that 40% of prisoners reported having used drugs since arriving at their current institution (EMCDDA, 2003; Lines et al., 2006). A national prison survey in England and Wales on drug use and initiation in prison revealed that more than a quarter of the heroin users reported that they had initiated use of this drug in prison (Boys et al., 1995).

For some prisoners, their sentence is seen as a time of abstinence, to help them recouprate from the damaging effects of using drugs, though this may just be a temporary reprieve. This often occurs in conjuction with a general improvement in their health, as often, prison drug treatment is the first time many users come into contact with any sort of support. It is also evident that on release, with a lack of support in the community, many users continue or restart their drug use (Turnbull et al., 1991).

Although injecting drug users are less likely to inject while in prison, those who do are more likely to share injecting equipment and with a greater number of people, as they can no longer access clean equipment within the prison (Lines et al., 2004). Studies have shown the impact of not providing such services, as in 1993, in the first documented outbreak of HIV, 43% of priosoners reported that they injected drug and shared equipment (Taylor/ Goldberg, 1996). A substantial number of drug users report having first started to inject while in prison Studies of drug users in prison suggest that between 3–26% first used drugs while they were incarcerated and up to 21% of injectors initiated injecting whilst in prison (EMCDDA, 2003).

Despite many control efforts illicit drugs get into prisons and prisoners consume them. Just as in the community, drugs are present in prisons because there is a demand and a market for them and because there is money to be made selling them. Many prisoners have a history of drug use or are actively using drugs at the time of incarceration. As such, drug users form a particularly over-represented group in the prison population in many countries (Kingma and Goos, 1997).

A typical profile for the group of drug users finally ending up in prison would include the following characteristics: socially deprived, poly-drug users with several stays in prison, having experienced several treatment attempts with a high incidence of relapse and with severe health problems, including incurable infectious diseases and mental illness. The number of drug-law offences in most EU countries has consistently risen over the past 15 years. As a result, the number of drug users in prisons has increased substantially (Stöver, 2001). In addition to those people who enter prison with a history of, or active, drug use, a substantial proportion of prisoners start using drugs while in prison as a means to release tensions and to cope with living in an overcrowded and often violent environment (Taylor et al., 1995).

For many prisoners, the first two weeks following release from prison is particularly dangerous, as many prisoners resume (higher levels of) drug use

and are at very high risk of drug overdose. In the week following release, prisoners are about 40 times more likely to die than the general population. In this period, immediately post-release, most of these deaths (over 90%) were associated with drug-related causes (Singleton et al., 2003). Prisoners who have not taken drugs frequently during detention often have difficulty in adapting to the new situation after release. They return to old habits and consume drugs in the same quantity and quality as before prison. The transition from life inside prison to the situation in the community is an extremely sensitive period. The longer a drug user stays in prison, the more difficult adapting to life outside prison will be. Even a prison sentence of only several weeks, during which no drugs are consumed, poses a considerable risk to released drug users: because of a reduced tolerance for opiates, even small quantities can be life-threatening (Stöver/Weilandt, 2007).

The risks associated with injecting drug use present clear threats prison health care services, and consequently to public health services (Ramsay, 2003). Drug using prisoners on short term setneces pose a particular problem, as they are unable to access treatment programmes and return to their families and communities with communicable diseases contracted in the prison, putting them at additional risk (WHO, 2001). There are clearly identifiable dangers of high risk behaviour (e.g. sharing of injection equipment, unprotected sexual contacts; and tattooing/piercing) in prisons, as needles and syringes not available and sexual activity is either ignored or denied completely. are contraband and thus scarce in the prison setting sexual relationships are a taboo. Blood borne infections (e.g. HIV, Hepatitis B and C) that are transmitted among drug users by unsafe injections, sexual practices, tattooing and piercing are massively over represented in prisons compared to the community (CEEHRN, 2007; Lines, 2007; Laticevschi, 2007). The prevalence of drug use and sharing injection equipment among incarcerated women is higher than that among incarcerated men (Stöver/Lines, 2006) and juveniles and migrants are at particular risk as they often have a poor understanding of the nature and character and the dynamics of infectious diseases in closed settings (MacDonald et al., 2007).

The additional problems faced by prison administrations throughout the EU in addressing health concerns of prisoners include the higher incidences of drug related deaths in prisons and shortly after release, suicide attempts, self harm and mental health problems (Bird et al., 2003; Bird/Hutchinson, 2006). These problems can also put prison staff at additional risk, for example

needle stick injuries during cell searches (Bögemann, 2007). Treatment for drug abuse and dependence and the related diseases (such as anti-retrovial and antiviral treatment) are limited compared to services in the community and prevention strategies (e.g. vaccination) are often not pro-actively offered. Harm reduction are also extremely limited within prisons and secure settings (MacDonald et al., 2007) and are considered highly controversial as a measure in the community, let alone in secure establishments (WHO, 2005).

In 1988, the WHO Regional Office for Europe (1990) developed recommendations for managing health problems of drug users in prisons. Since then, other efforts to address problems related to drug use in prisons have been undertaken, including efforts to tackle drug users' health problems in juvenile (WHO Regional Office for Europe, 2003a) and adult prisons and the whole criminal justice system (WHO Regional Office for Europe and Pompidou Group of the Council of Europe, 2002).

4.1.3 Injecting drug use and communicable diseases

In Europe the HIV prevalence among prisoners is primarily related to the sharing of injecting equipment inside and outside of prisons. Sharing syringes among intravenous drug users is a high-risk activity for the transmission of HIV due to the residual presence of blood in the syringe after injecting (Shah et al., 1996; Shapsak et al., 2000). Given the secure environment of penal institutions, it is often more difficult to smuggle syringes into prisons than it is to smuggle in drugs (Lines, 2002). As a result, syringes are typically scarce, and prisoners who inject drugs share and reuse syringes out of necessity (WHO, 2004). For people who inject drugs, imprisonment therefore increases the risk of contracting blood-borne infections such as HIV, through sharing needles.

Needle-sharing is prevalent in many prisons visited, but prisoners who use drugs on the outside usually will reduce their levels of use in prison. Many studies from countries around the world report high levels of injecting drug use, including among female prisoners. Studies also show that:

- The extent and pattern of injecting and needle sharing vary significantly among prisons;
- many people who inject before imprisonment reduce or stop injecting when they enter prison, but many resume injecting upon release either on a regular or occasional basis

- some people start injecting in prison ; and
- those who inject in prison usually inject less frequently than outside but are much more likely to share injecting equipment than are drug injectors in the community; further, they are sharing injection equipment with a population – fellow prisoners – that often has a high rate of HIV and hepatitis C virus infections (Stöver, 2002).

In a prison, a syringe may circulate among (often large) numbers of people who inject drugs, or be hidden in a commonly accessible location where prisoners can use it as necessary. A needle may be owned by one prisoner and rented to others for a fee, or it may be used exclusively by one prisoner, reused again and again over a period of months until it either disintegrates, is rendered totally unsuable or is confiscated by prison staff (Lines, 2002). Sometimes the equipment used to inject drugs is homemade, with syringe substitutes fashioned out of available everyday materials, often resulting in additional vein damage, scarring, and injecting-site and other infections.

Injecting drug users (IDUs) in prisons cannot be considers a homogeneous population, but instead constiture a variety of subgroups which require targeted interventions. These can include those who have injected prior to prison, but no longer inject in prison; those with no previous history of injecting; those who may have smoked or injested drugs prior to prison but start to inject during their sentence; occasional injectors; independent injectors, who are disciplined about harm reduction and do not share their injecting equipment; closed-circle injectors, who share equipment only within their own group; renters, who rent injecting equipment from others for money, drugs or favours and hirers, who own injecting equipment and rent it out for a fee or service (Shewan et al., 2005). Clearly these different groups present different levels of risk of contracting communicable diseases, and moreover, are likely to contain both HIV positive and HIV neagtive prisoners whose health needs will be different.

A national study in the US of 25,000 people who inject drugs found that approximately 80% had been in prison at some time (Dolan, 1999). A 1995 World Health Organization (WHO) study of HIV risk behaviour among people who inject drugs in 12 cities found that 60% to 90% of respondents had been in prison since commencing injecting drug use, with the majority experiencing incarceration on multiple occasions (Ball et al., 1995).

This is not to say, however, that prison has no effect on patterns of drug injecting. In fact, research has demonstrated that incarceration affects patterns

of injecting and decisions about injecting in various ways, often with the result of increasing the risk of transmission of HIV and other blood-borne diseases. For example, while people who inject drugs typically inject less frequently in prisons (Shewan et al., 1996), studies have found that injecting tends to take place in a more "high-risk" fashion than injecting outside of prisons (Darke et al., 1998; Malliori et al., 1998). Drug users often choose to inject in prison when they would not normally inject outside prison, and networks of drug users who share injecting equipment can be larger in prisons than outside prisons (Long, 2003; Lines et al., 2006). As stated by UNAIDS:

> Long experience has shown that drugs, needles and syringes will find their way through the thickest and most secure of prison walls (UNAIDS, 1997, p. 6)

Research has revealed a number of factors that encourage drug injecting among prisoners, or the switch to injecting among non-injectors. The inconsistent or scarce supply of drugs such as heroin is one. Because injecting is a more efficient means of drug consumption, resulting in less waste, it has been shown that some heroin smokers will elect to inject heroin rather than smoke it while incarcerated. The prison economy may also prove a factor, and provide an incentive for prisoners who "own" a syringe to rent it or trade it to others in exchange for drugs (Long, 2003). In addition to the extensive evidence of high risk behaviours among prisoners in many countries, there is also documented evidence of the tranmission of HIV, as well as blood-borne infections such as HCV, within prisons (Lines/Stöver, 2006).

4.1.4 Unprotected sex in prisons

Unprotected sexual contacts between prisoners pose a risk for the sexual transmission of HIV, Hepatitis and other sexually transmitted diseases. Within penal institutions, sexual contacts occur in different ways, and in varying frequencies. Sex maybe consensual, or it may be forced or coercive. Sex may also be used as a form of currency within the prison and exchanged for money, protection, property, or drugs. Violent forms of unprotected sexual anal or vaginal intercourse, including rape, carry the highest risk for transmission HIV, particularly for the receptive partner who is more likely to suffer damage or tears in the membranes of the anus or vagina (Betteridge, 2004).

Same-sex sexual activities are the most common forms of sexual contacts in prisons. Although homosexuality has been decriminalised in many countries, significant stigma is still attached to same-sex sexual activities (particularly male homosexuality) in many societies and in many prison systems. This stigma can lead to discrimination by other prisoners and staff members. Men having sex with other men in particular may be subject to violence, discrimination, and social exclusion. These negative consequences can make sexually active male prisoners even more vulnerable to HIV infection by deterring them from accessing safer sex measures such as condoms (in prisons that provide them) for fear of identifying themselves as sexually active. Many prison systems maintain prohibitions against any sexual activity (whether consensual or non-consensual) that can also create barriers to prisoners accessing safer sex measures such as condoms.

The prevalence of sexual activity in prison is influenced by factors such as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification, and the extent to which conjugal visits are permitted. Given the stigma in most societies against same-sex sexual relationships, levels of sexual activity among prisoners are difficult to estimate with any accuracy as these relationships (whether consensual or forced) generally occur in secrecy. Risk behaviour studies within prisons may also under-record the true amount of sexual activity, as many prisoners may be reluctant to disclose same-sex sexual behaviours to researchers (Long et al., 1999).

That said, several studies have provided evidence that significant rates of risky sexual behaviour occur in correctional settings. Studies of high-risk behaviour show widely varying estimates of the proportion of male prisoners who have sex with other men (Okie, 2007). They range from 2 to 65% and estimates the proportion who are sexually assaulted range from 0–40% (Krebs, 2006). A study conducted among 373 male prisoners at all of South Australia's prisons (Gaughwin et al., 1991) concluded that 12% engaged in anal intercourse at least once. Another study in South Australia (Douglas et al., 1989) reported that prison officers and prisoners estimated that between 14% and 34% of prisoners engaged in 'occasional anal intercourse'. From a research in New South Wales (Potter/Conolly, 1990), in which interviews were conducted with a random sample of 158 prisoners (142 males and 16 females), seven per cent of the men reported having had voluntary adult homosexual experiences in prison. The European Network on HIV/AIDS

and Hepatitis Prevention in Prison found rates for sexual intercourse among men in prison of between 0.4% (Sweden), 1.4% (Austria) and 5% (Spain). The rates of condom use for the last intercourse were between 0% (Belgium) and 30% for Spain (Rotily et. al., 1999). In the Austrian contribution to that Network study (Spirig et al., 1999) it was found that 2.8% of the men stated that they were raped in prison, 1.4% stated that they had sexual intercourse with another man in prison, no one stated they had accepted payment for sexual intercourse, and no one stated they had used a condom. The nature of the prison's physical environment (i.e., individual cells, shared cells, shared living units, dormitories, barracks) can have particular impact on levels of coerced sexual activity, sexual abuse, and rape. Prison policy that allows children and young people to be housed with adults can also increase the vulnerability of young prisoners to sexual abuse. Staffing levels and levels of supervision of prisoner living areas can also have an impact on levels of sexual activity, both consensual and coerced. Although most sexual contacts in prisons are same-sex activities, heterosexual contacts may also take place. These may occur between prisoners and prison staff (which may be coercive in nature, particularly for female prisoners) or during prison visits (whether or not such visits are official "conjugal" in intent).

4.1.5 Tattooing and body piercing

Tattooing amongst prisoners is a common practice in many countries. Research has revealed high levels of tattooing among prisoners countries including Australia (Dolan, 1999), Canada (Correctional Services Canada, 1996), Ireland (Long et al., 1999), Spain and the United States (Dolan, 1999).

Because tattooing involves breaking the skin with a needle, it is an activity that poses a risk of transmission of blood-borne diseases though the sharing and reuse of tattooing equipment such as needles and inks – both of which come into contact with large amounts of blood during the tattooing process. Tattooing and the possession of tattooing equipment are prohibited by prison authorities in many countries, and those found to be engaging in tattooing are subject to punitive sanctions. As a result, tattooing is an activity that takes place secretively, often in unhygienic environments, using homemade equipment and inks, and as quickly as possible so as to minimize the risk of detection by prison staff. All of these factors increase the risk of negative health consequences via tattooing in penal institutions.

Conclusive clinical evidence of HCV or HIV transmission via tattooing is elusive. One of the barriers to demonstrating a clear causal relationship between the transmission of blood-borne disease and tattooing, particularly among prison populations, is the very high level of injecting drug use history among this group. It therefore becomes difficult to identify conclusively whether the source of infection was tattooing or syringe sharing. However, despite a lack of definitive evidence, there is significant anecdotal evidence of blood borne disease transmission through tattooing (inside and outside prisons), as well as a body of scientific opinion identifying the potential health risk when tattooing occurs in a non-sterile environment. Several studies of prison populations have found evidence linking tattooing to the transmission of blood-borne diseases in prisons (Holsen et al., 1993; Thompson et al., 1996; Post et al., 2001; Estebanez Estebanez, 1990; Samuel, 2001).

On the related issue of body piercing, a review of various studies on the relationship between piercing and hepatitis transmission concluded that eight of twelve studies identified percutaneous exposure, including body piercing and ear piercing, as a risk factor for viral hepatitis. Six of the studies found that hepatitis seropositivity was significantly associated with ear piercing (Hayes and Harkness, 2001). Exposure to human blood and body fluids (if infected with HIV/HCV) has the potential for transmitting infections. Within prisons, both prisoners and prison staff may be exposed to human blood or other body fluids as a result of assaults, accidental needle stick injuries and carrying out medical duties.

4.2 Prison as a high risk environment

Prison conditions are integrally linked to the physical health and mental well-being of prisoners. Poor living conditions can contribute to an increased risk of HIV transmission in prisons and a decline in the health of prisoners living with HIV/AIDS. First, substandard conditions can increase the risk of HIV transmission by promoting and encouraging drug use, (which usually involve unsafe injecting practices) to escape boredom or stress. They can also contribute to the increased risk of prison violence, sexual coercion and rape. Secondly, among prisoners living with HIV/AIDS, poor conditions can increase vulnerability to a decline in health by exposing them to contagious diseases and opportunistic infections; placing them at risk for dual infection with either TB or hepatitis; housing them in unhygienic and unsanitary environments; confining them in spaces that do not meet basic needs for size,

natural lighting, and ventilation; failing to provide them with proper diet, nutrition and/or clean drinking water; and housing them in overcrowded, high-stress environments. Minimum standards for the housing and treatment of prisoners are defined by international agreement, yet many prison systems in Europe – whether in high-income countries or countries in economic transition – fail to meet these standards, due to strained financial resources and/or a lack of political and public interest in the well-being of prisoners. Failure to improve such confinement conditions can undermine the effectiveness of HIV/AIDS programmes and strategies (MacDonald, 2005; Lines et al., 2004).

4.2.1 Overcrowding and the over-representation of risk groups

Worldwide over 9 million people are held in penal institutions throughout the world – about half of these in the US, Russia or China (Walmsley, 2003). In the 27 European Member States more than 600,000 people are incarcerated in prisons on a given day[3]. The turn over rate is estimated to be at least threefold, which means that around 2 Mio. people pass EU-custodial institutions annually. In average, the prison population rate per 100,000 inhabitants in the European union is 121.6 (with large variations between 56.4 in Slovenia and 337.9 in Estonia). In average, more than 5% of the prison population are female prisoners.

Despite several attempts to improve the situation, nearly all prison services in the EU Member States are reporting overcrowding (Walmsley, 2003). A majority of 16 countries plus Bulgaria and Romania show a prison density per 100 places between around 90 and about 120. The highest rates can be found in Cyprus, Greece and Hungary (160.6% to 144.9%) and the lowest in Malta (62.6%). The EU average for occupancy level is 109.6%, indicating a general tendency of overcrowding in the prisons throughout the European Community[4].

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3 The prison population in the member states of the European Union comprises 558.025 prisoners (including pre-trial prisoners) on 1st September 2004, while 40.085 persons in Romania and 10.935 persons in Bulgaria, were in prison at that time. Source Council of Europe Annual Penal Statistics: SPACE I http://www.coe.int/t/e/legal_affairs/legal_cooperation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp.

4 Source Council of Europe Annual Penal Statistics: SPACE I http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp.

Generally in many countries the number of prisoners has dramatically increased over the two last decades (Stöver/Weilandt, 2007). Research has demonstrated the detrimental impact of overcrowding in prisons, in relation to security issues and also on prisoners' health and access to other services such as education, work and visits from family members and other external organisations. With regards to prisoner health, overcrowding presents additional risks for prisoners with HIV or other infectious diseases, as they often experience poor nutrition, limited access to treatment and are also often engaged in high risk behaviours such as injecting drug use, sexual activity and tattooing (WHO, 2005; Lines et al., 2004; Tkachuk/Walmsley, 2001). Overcrowding in prisons has also been shown as a key factor in increasing levels of self-harming and suicide among prisoners, higher prevalence of mental illness among prisoners and also as having a detrimental impact on resettlement and rehabilitation strategies (Howard League for Penal Reform, 2001).

Table 3: Prison population and capacity rate for the sample countries

Country	Prison Population (date)	Number of prisons	Prison population rate (per 100,000 of national population)	Capacity (2006)
Austria	8,766 at 9.6.2006	28	105	107.2%
Bulgaria	11,436 at 1.1.2006	13	148	130.9%
Estonia	4,463 at 1.10.2005	7	333	102.2%
Germany	77,166 at 31.8.2006	195	94	96.5%
Italy	61,721 at 30.6.2006	225	104	131.5%
Lithuania	7,983 at 1.11.2006	15	235	84.6%
Poland	89,546 at 30.11.2006	213	235	124.4%
Romania	34,542 at 28.11.2006	45	160	91.1%
Spain	63,991 at 29.12.2006	77	144	129.5%

Source: Roy Walmsley, World Prison Brief
* (includes prisoners under 21 who were sentenced when they were under 18)

Table 6 presents details of the national picture for each of the countries visited in relation to the level of overcrowding and rates of imprisonment. The impact of overcrowding was highlighted by many of the institutions visited, and often relates to problems in providing healthcare and harm reduction services for prisoners. This, in conjunction with staff shortages often means prisoners are not getting adequate treatment and are not given the opportuni-

ties to seek support. At a national level, as shown in table 3, overcrowding rates (i.e. those where capacity is above 100%) range from relatively small, at 102.2% (Estonia) to significantly higher (e.g. 130.9% in Bulgaria and 138.9% in Italy). Among the countries visited for this study, Germany, Lithuania and Romania were not experiencing overcrowding.

4.2.2 The principle of equivalence for health care in prisons

Guidelines developed from the WHO (EUROPE) Health in Prisons Project and the Pompidou Group of the Council of Europe (2001) principles for the provision of healthcare services in prisons state that:

> 'There should be health services in prisons which are broadly equivalent to health services in the wider community.' (WHO, 2001)

They also recommend services are based on clearly assessed needs of prisoners, who are often from socially deprived groups and present additional problems. This will include identifying problematic drug users and those with communicable diseases such as HIV and hepatitis who need additional support as well as healthcare. A key element of this process should be to consult with prisoners themselves and allow them to take some responsibility in planning their treatment. These guidelines are not only in place to assist prisoners but also the prison and healthcare services on a wider scale by preventing the spread of communicable diseases, promoting healthy lifestyles and reducing the personal and environmental harm resulting from high-risk behaviours. However a studies into healthcare services in prison systems in the EU revealed that due to staff shortages and limited budgets, this was often difficult to achieve, despite the implications for the human rights of prisoners (MacDonald, 2005; Haton and Boyington, 2006). In addition, further guidelines have emphasised the need for healthcare in prison to be *at least* equivalent to community provisions, and in recognition of the additional needs often presented by prisoners and also of the lack of provision available for some groups in the community, to in fact be better than community healthcare.

Research from the US has emphasised the need to establish equivalence of care in prison health services with those provided in the community, in order to reduce the 'adverse health and social consequences of current incarceration policies' (Freudenberg, 2001). The principle of equivalence also suggests that harm reduction measures available in the community should be implemented in prisons, including:

> Confidential testing with pre- and post-test counselling, effective treatment, public information campaigns, personal information and counselling, group education on safer drug use and safer sex, peer education and peer led initiatives, vaccination against those viruses where such vaccines are available and approved (e.g. hepatitis B), advice on using bleach or other disinfecting methods to clean needles and syringes, the provision of sterile needles and syringes, and the provision of condoms. (Pompidou Group, 2001)

Whether a person living with HIV/AIDS lives in prison or in the outside community, they have very similar medical care, treatment, and support needs. However, within many prison systems, lack of funding and medical infrastructure, lack of properly trained medical staff, lack of access to antiretroviral therapies (ARVs) and other HIV treatments, and inappropriate prison policies and practices mean that HIV-positive prisoners often live in conditions that increase their vulnerability to medical neglect, opportunistic infections, needless suffering, and untimely death[5].

4.3 Treatment, prevention and education programmes for prisoners

Prison-based treatment programmes have a tendancy to focus on abstinence as the main goal as opposed to maintenance, as shown by a lack of substitution treatment programmes (Marlatt/Witkiewitz, 2002). Abstinence-based treatment programmes provide a good opportunity for those prisoners who are motivated and capable to cease using drugs. There is evidence that drug free-treatment which is available as an option in prisons is effective, whether it was started before or during imprisonment. There is also evidence that substitution maintenance treatment for heroin dependence (mainly methadone or buprenorphine treatment) is also effective.

However, it is important to accommodate those prisoners who are not motivated to stop using drugs, but do need to better understand how to reduce the harms associated with drug use. Research has highlighted the need for treatment providers, in any setting, to identify the needs of clients and their goals, whether this be maintenance or abstinence, and provide support in accordance with this (Marlatt/Blume/Parks, 2001; Stöver et al., 2004). All in all it can be stated that:

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5 Guiding questions for scrutinizing the prison health care services come from the CPT and are extremely helpful (Council of Europe, 1999).

> Positive experience from in-prison treatment helps inmates to continue treatment after release, reduce relapse rates and related health risks, and also reduce delinquency recidivism. (The Lisbon Agenda for Prisons, 2006)

4.3.1 Testing of Infectious Diseases and HAART

According to the WHO database on disease testing in prison elaborated by the WHO/Europe[6] disease testing mostly takes place on admission rather than on release, with the exceptions of Estonia and Lithuania[7] where HIV (but not Hepatitis) is tested both on admission and on release. Still there do exist policies of mandatory HIV testing (Latvia, where testing is mandatory for all prisoners, and the Czech Republic, where testing is mandatory for all risk groups). In many countries, marginalised HIV-infected populations, such as prisoners and others (ethnic minorities, migrants, etc.) have been excluded or have been delayed from receiving appropriate care. Limited supply of ART and the suggestion that these populations may be less adherent to ART than other HIV transmission categories have been extensively used to justify such limited access (Carrieri/Spire *forthcoming*). This mirrors the situation in the wider community, where the coverage among current/former IDUs seems to be substantially less than other exposure categories. Ongoing monitoring of ART by exposure and population subgroups is critical to ensuring that scale-up is equitable, and that the distribution of ART is, at the very least, transparent (Aceijas et al., 2006).

4.3.2 Hepatitis vaccination

In many countries Hepatitis poses an even bigger problem than HIV-infections to drug using prisoners. Throughout European Prisons HCV prevalence of more than 80% are reported, a high percentage of HIV-positive prisoners are co-infected with HCV. Any other burden (e.g. HAV or HBV infection) for the immune system of individuals is a severe health damage and needs to be avoided (Stöver, 2007; CEEHRN, 2007). Due to the high turn over rates, screening and vaccination for hepatitis A+B often remain incomplete. As Hepatitis B infection may constitute a severe co-infection to HIV/AIDS the risk of acquiring an infection in prisons may be reduced by a vaccination both for prisoners and for staff. Moreover this measure is cost-effective. The

6 http://data.euro.who.int/hip/

7 Personal communication with prison doctor.

efforts undertaken to prevent infectious diseases in prisons should not be restricted to reduce the spreading of HIV but should also be designed to reduce the risk 'hepatitis infections', particularly among injecting drug users in detention. Low HBV vaccination rates, the lack of clear procedures and protocols in many prison systems to offer HBV vaccination leads to reduced benefits for the prisoners, despite the fact that the prison setting present a good opportunity to offer and conduct vaccination (Gilbert et al., 2004; Sutton et al., 2006a; 2006b).

At the moment there are low coverage levels on proportion of the IDU population that may be vaccinated in many prison systems at reception and during the sentence. In 1999 the Scottish prison service implemented an initiative to offer HBV vaccination to all prisoners. Data has shown in Glasgow in the two years since the introduction of the initiative the uptake of at least one dose of HBV vaccine had more than tripled (16% to 52%) among recent initiates to injecting drug use (in this case those that had started injecting in the previous five years) 56% of which reporting having been vaccinated in prison (Hutchinson et al., 2004). In addition, the proportion of all HBV reports with exposure data indicating injecting drug use in Scotland have shown a reduction from 30% in 1999 to 6% in 2005 (Health Protection Agency, 2006).

4.3.3 Drug testing

Mandatory drug testing in prisons has a significant effect on drug use among prisoners (MacDonald/Harvey, 1997; Edgar/O'Donnell, 1998). Many prison systems, particularly those in the developed world, routinely and/or randomly test prisoners for illicit drug use, most often by urinalysis. Prisoners who are found to have consumed illicit drugs can face penalties under criminal laws or administrative/institutional penalties, which can result in loss of privileges or an increase in the amount of time a prisoner will be incarcerated. Therefore, there is a great incentive for prisoners who use illicit drugs to avoid detection. While urinalysis can detect the presence of drugs in urine, some drugs clear the human body in relatively short order (e.g. heroin), while other drugs remain detectable for much longer periods of time (e.g. cannabis). Particularly significant in the context of HIV transmission in prisons, smoked cannabis is traceable in urine for much longer (up to more than one month) than drugs administered by injection, such as heroin and cocaine (Jürgens, 2002). Therefore, it is logical that some prisoners choose

to inject drugs (with serious public health impacts) rather than risk the penalties associated with smoking cannabis (which has a negligible public health risk) simply to minimise the risk of detection and punishment. Due to the lack of sterile needles and the frequency of needle sharing in prison, the switch to injecting drugs has detrimentel health consequences for individual prisoners, including the potential for transmission of blood-borne diseases (Gore et al., 1996; Lines et al., 2006).

4.3.4 Information, education and communication for prisoners and prison staff

Providing information and education on HIV transmission, transmission routes, and prevention strategies is typically the first approach in developing an HIV programme in prisons. Developments in several countries have shown that the justice system is an important setting for the education of groups or individuals who are potentially at risk of becoming infected with HIV, or other blood-borne or sexually transmitted infections. Individuals arrested, detained or incarcerated, in police stations, pre-trial detention centres or penal institutions, can be informed, trained, and provided with the means to protect themselves. Often they are in contact with help facilities for the first time in their life, even though they may have been drug users for a fairly long period of time. Prison-based services should include the same range and quality of education programmes offered in the community[8], and provide accurate information in a non-judgemental fashion. Prison-based educational programmes on HIV/AIDS, drug use, and sex work can be more successful when they reflect an integrated approach between prison and community health services, bringing prison health and public health services closer together.[9] Information about HIV/AIDS is generally regarded as a prerequisite for effective HIV prevention programmes, and there is no evidence to show that education is sufficient on its own.

8 See for instance: Prevention of HIVtransmission among drug users. A training manual for field level activities.

9 See WHO Moscow Declaration.

In developing educational initiatives, the following targets should be met:

- To raise awareness of health problems connected to drug use, drug-related infectious diseases, drug injecting, sexually transmitted infections and tattooing and piercing.
- To initiate and support a discussion about risk reduction as response to these health problems.
- To increase the knowledge and skills of both prisoners and staff with regard to drug use, drug related infectious diseases, drug injecting, STIs, tattooing and piercing as health problems.
- To encourage a positive attitude towards risk reduction activities by both prisoners and staff.
- To disseminate accurate and non-judgemental information relevant for HIV prevention and health promotion by a range of means.
- To stimulate and support the realisation of risk reduction activities for prisoners as well as for staff members.

Education strategies should include[10]:

- Accurate and non-judgemental HIV/HBV/HCV information must be widely available and in the relevant languages.
- Prison and community-based programmes should be integrated/connected and offered on an ongoing basis.
- Demand reduction efforts should be undertaken to support and motivate prisoners to abstain from drugs during imprisonment.
- Safer drug use information to avoid HIV transmission and other health damage related to intravenous drug use and the sharing of injecting equipment.
- Safer sex information adjusted to specific life settings (i.e., private relations, sex work).
- The methods applied should reflect the growing need for interactive learning[11].
- Peer-education initiatives and materials should be encouraged and supported.

10 See Stöver, H.; Trautmann, F. (ed., 2001): Risk Reduction For Drug Users In Prisons. Utrecht/The Netherlands.

11 See for example Stichting Mainline (2000): Rate your Risks. The Facts about Infections. Amsterdam/The Netherlands.

- Relapse prevention programmes (how to avoid recidivism and overdose after release).
- Services must meet needs and individual resources of the concerned.
- Delays and barriers to access support and counselling must be minimised.
- Consistent availability of services and support.
- Safer drug use, safer sex and safer work (re sex work) seminars should be offered.

Education on HIV/AIDS for both prisoners and prison staff is usually provided at the beginning, when a person first enters prison or begins new employment. Ongoing refresher courses and seminars should be used to sustain and reinforce the HIV/AIDS related health messages.

Modern educational methods, peer education initiatives, and visual aids are now well-established and should be encouraged and supported. Information should be delivered through a variety of channels, including:

- General awareness campaigns, including general education sessions by prison staff, posters, pamphlets, and other materials.
- The provision of targeted information through health and social services frequented by injecting drug users or sex workers .
- Peer education and outreach, particularly to drug users and other marginalised populations within the prisons.
- Involvement of civil society and other health professionals from outside the prison.
- Face to face communication, particularly to support drug users and sex workers to turn information into actual behaviour change through a process of clarification and reinforcement.

Harm reduction services, the embedding of educational programmes into comprehensive prevention, and treatment and support packages for injecting drug users and sex workers can be crucial for their success. Psycho-social support is known to add a major additional help to such programmes. Information and/or training before release to prepare prisoners with experience of drug use and/or sex work for the risks faced after release (information about enhanced overdose risk after release, safer injecting, safer sex etc.) is a service available in only a few prisons, and should also be developed.

4.3.5 Prison based drug demand reduction programmes

Although the provision of prison based treatment programmes varies considerably throughout the EU, the key elements include therapeutic communities, drug free wings, testing prisoners and cognitive-behavioural programmes. In some countries harm reduction services are also in place, though to a limited degree, and often include information and referral services, condom provision and bleach, with some exceptional cases of needle exchange programmes and substitution treatment.

Therapeutic communities offer support for prisoners suffering from 'emotional disturbance' in a group setting and are based on principles of a 'collaborative, democratic and de-institutionalised approach to staff-patient interaction'.[12] As prisoners are effectively a captive audience, this offers some advantages to prison based therapeutic communities, however, the regime can also impede such programmes effectiveness, due to strict regulations impacting on group and individuals' decisions regarding treatment. Drug free wings are formed on separate sections within prisons, offering support to those prisoners who wish to cease all types of drug use (including smoking). Prisoners are routinely testing, attend regular and often intensive counselling programmes and group activities, including cognitive behavioural programmes. They are designed for those prisoners who are focus on ceasing drug use during their sentence and also provide after care services once prisoners are released (Hough, 1996).

Since intravenous drug use, specifically the sharing of injecting equipment, is a main transmission route of infectious diseases such as HIV/AIDS, reduction of drug demand is a basic HIV/AIDS prevention strategy.

Drug demand reduction in this context basically refers to treatment programmes[13] in the prison setting.[14] The goal is of these programmes is to support prisoners in leading a drug-free life in response to an awareness of risks

12 See http://www.therapeuticcommunities.org/faq.htm.

13 A broader definition of drug demand reduction includes prevention and rehabilitation as well.

14 The importance of drug problems in prisons has been recognised internationally. In the 'Declaration on the guiding principles of drug demand reduction', which accompanied the UN General Assembly Special Session on Drugs (UNGASS) in 1998, prisoners were explicitly identified as an important group for demand-reduction activities. See UN: Twentieth special session of the General Assembly, devoted to countering the world drug problem together with the Declaration on the guiding principles of drug demand reduction.

associated with the use of drugs especially in the prison setting. According to Turnbull, 80% of all Council of Europe countries have abstinence-based programmes. Turnbull states that:

> One of the main reasons why this approach has been adopted within prisons is the perception that prison culture often works against other types of treatment and education programmes. (Turnbull, 2000, 47F)

Another reason is that abstinence is compatible with, and reinforces, the aim of custody in general, and is seen to enable prisoners to lead a life without committing criminal offences after release. Within prisons, the use of illegal drugs is a criminal offence, and therefore abstinence-based interventions are generally viewed as compatible with the goal of many prison systems to seek to eradicate drug us inside prison.

Studies indicate that it is important for prison systems to develop particular strategies for prison drug treatment rather than simply just reflecting those strategies that exist in the community (Turnbull and McSweeney, 1999). Continuity of treatment provision is an important factor, particularly as aftercare following release and this is linked to re-offending rates (Porporino et al., 2002). Generally there is a growing consensus that drug treatment programmes in prison can be effective if they are based on the needs and resources of prisoners and are of sufficient length and quality (Ramsay, 2003).

Abstinence oriented treatment provided predominantly in special facilities (drug-free wings, therapeutic communities) is the dominant approach of existing prison-based interventions. Some countries show an increase of drug-free areas since the mid-nineties, e.g. 300–400% in Austria, England and Scotland, (Turnbull, 2000:48). Access to these programmes is voluntary under certain conditions, sometimes even with contracts for behavioural change. The central objective is abstinence. Therefore urine testing plays a major role to ensure the drug-free status. These programmes are mostly run in separate sections of the prison with no direct contact with other prisoners and a high control standard. The ‘12 steps’ or Minnesota concept is the most common. Drug-free wings have been developed especially in Austrian, Dutch, Finnish, and Swedish prisons, among others.

Overall surveys for England and Wales indicate that half of the women and a third of the men who were identified as drug dependent in the year before entering prison received help for their drug problem during the time of imprisonment. Also, a substantial proportion had some contact with help

agencies during their prison stay. Those with opiate dependence were more likely to receive help in the community and were also more likely to receive help in prison, but dependent stimulant users also reported significant levels of access to help within the prison setting.

In most countries, a differentiated system of sanctions and incentives has been developed in prisons in order to punish drug-using behaviour or to reward those who remain abstinent within a unit or a treatment programme. Sanctions can include additional days of imprisonment[15]; removal of privileges and work opportunities; removal of home leave and visits. Alternatively, incentives are designed to encourage good behaviour of prisoners and may include transfer to a drug-free wing; single cell occupancy; additional home leave and a television in the cell. Evaluations of such programmes have also yielded some promising results with respect to high-risk behaviour among drug-dependent prisoners (WHO/UNAIDS, 2004).

In view of the increase in drug consumption in many prison systems of, it is imperative to provide adequate helping services that meet the needs of drug users. The measures taken must be balanced with the requirements for security and good order, and be consistent with human rights norms and standards. The goals pursued should also be pragmatic, not only with respect to the prison system but also with respect to the prisoners. Therefore, the reduction of harmful drug use and risk behaviours should be the guiding philosophy behind the measures. The spatial and methodical range of action for implementing remedial measures in prisons is very limited. Due to the increased risk behaviours associated with drug use in prison there are many arguments against the systematic use of imprisonment for those who are involved in crime and drug use. Prison generally does not have a rehabilitative effect on those it contains. There are harmful consequences of drug use in prisons, and learning to be drug-free in prison does little to prepare drug-using offenders for being drug-free on their return to the community. Prisons may exacerbate harms caused by drug use, and this harm may then be translated to the community outside of prisons (Turnbull and Webster, 1998).

15 The additional days given as punishment for drug offences in England and Wales in 1997 amounted to an extra 360 prisoners places per year (Prison Service Drug Strategy).

4.4 Harm reduction in prisons

Harm reduction is an important public health measure because reusing and sharing needles or other equipment for preparing and injecting drugs represent a highly efficient method of transmitting HIV and hepatitis C. In the absence of harm reduction activities, HIV prevalence among injecting drug users can rise to 40% or more within one or two years after the virus is introduced in their communities. Worldwide, more than 114 countries now report HIV epidemics associated with injecting drug use.

However, the WHO Health in Prisons Project is concerned with all the negative health effects arising from imprisonment. These include the impact on mental health, the risk of suicide and self-harm, the need to reduce the risk of drug overdose on release and the harm resulting from inappropriate imprisonment of people requiring facilities unavailable in prison or in overcrowded prisons. Harm reduction programs aim to limit as far as possible drug-use related health risks. The theme of these harm reduction programs is: 'If you use drugs in prisons, do it as 'safely as possible!' and 'Behave yourself as if everybody is positive' (Trautmann/Stöver, 2001). The practical support for users matches the individual needs and resources of the drug users.

Harm reduction measures are highly politically loaded, cannot be introduced due to resistance of staff, or are perceived as inappropriate for the prison setting (e.g. needle exchange). The introduction of harm reduction measures is relatively new to prison systems and is often perceived as threatening to the traditional abstinence-oriented drug policy in prisons. The goal of abstinence which is the ultimate goal is presupposed to be achieved in prisons and abstinence is seen as covered with the goal of the sentence (to lead a life without committing crime). Various harm reduction measures are generally seen as undermining the security measures of the prison system. This is different due to different measures. Substitution treatment for instance is more and more seen as a medically supervised adequate treatment of opioid dependent prisoners. The benefit for the whole system in keeping the institution 'calm' is more and more seen as a benefit arising from prescribing the substance (see Stallwitz/Stöver, 2007). This is different when it comes to prison needle exchange projects, which are perceived as undermining the goal of abstinence and needles are symbolized as 'giving up' – a failure to control drug traffic within the institution as well. Furthermore they are seen as instrument to threaten staff and prisoners. However, it is recognised that these concerns are often the result of failing to see harm reduction as more effective treat-

ment and care for prisoners with special needs. The positive aspects and results from scientific work has not been communicated as it is needed. An important aspect of the thinking behind harm reduction is to add another valuable element to the health care of drug-dependent prisoners and to reduce the health risks to personnel.

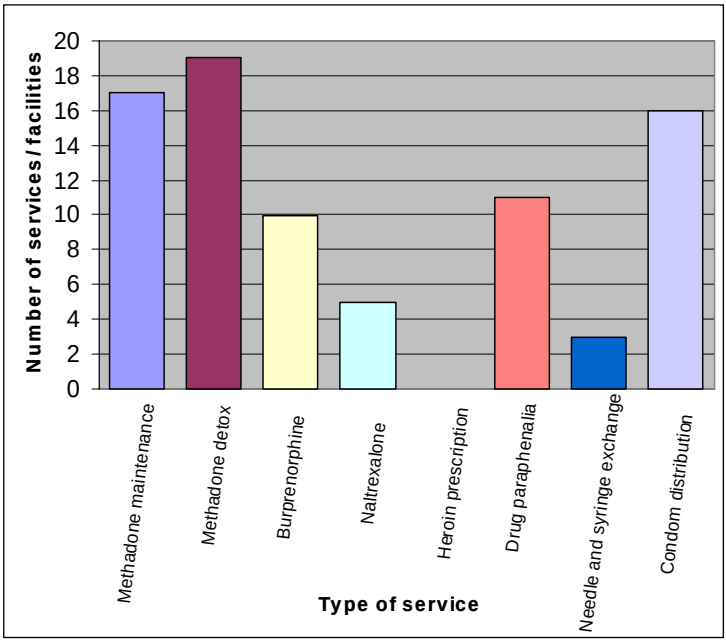
Despite the problems inherent in implementing harm reduction measures, many aspects of harm reduction are now widely accepted and applied throughout Europe. An analysis of prison-based programmes contained in the EMCDDA information system Exchange on Drug Demand Reduction Action (EDDRA) (Merino, 2003) found that about one fifth of the prison interventions had reducing drug-related harm as their main objective. Prison systems in Europe are often especially reluctant to support the introduction of needle- and syringe-exchange schemes because they feel it might lead to an increase in injecting drug use, accidental needle pricks and conflicts between prisoners or between prisoners and staff and the risk that syringes or needles would be used as weapons. Evidence shows that schemes have been introduced in prisons in Spain and in five other European countries without these problems arising (Lines et al., 2004; Stöver/Nelles, 2003). Nevertheless, harm reduction in prisons involves much more than needle-exchange schemes. Useful harm reduction programmes can still be established where such schemes are currently not being considered.

The implementation of harm reduction programmes is quite heterogeneous in European prisons. In a report of the implementation of the Council Recommendation (of 18 June 2003[16]) on the prevention and reduction of health-related harm associated with drug dependence[17] it is said that a policy to provide drug users in prisons with services that are similar to those available to drug users outside prisons exists in 20 Member States and is about to be introduced in four countries (see Figure 5).

The background document reports that needle and syringe exchange programmes in prison are probably effective in reducing needle sharing among injecting drug users and the transmission of drug-related infectious diseases and may also reduce abscesses.
The distribution of drug paraphernalia is not a common practice in the prisons (11 countries only). Three countries provide needle and syringe ex-

16 http://europa.eu.int/eur-lex/pri/en/oj/dat/2003/l_165/l_16520030703en00310033.pdf
17 http://ec.europa.eu/health/ph_determinants/life_style/drug/drug_rec_en.htm

change in prisons. In Spain, for example, a needle and syringe exchange programme is available in 42 prisons.
Substitution and detoxification treatments are available in prisons in, respectively, 17 and 19 countries although the coverage varies greatly. Condom distribution is available in prisons in 16 countries.



Source: Adapted from COMMISSION OF THE EUROPEAN COMMUNITIES 18.4.07

Figure 4: Harm reduction services in prisons

4.4.1 Needle exchange programmes in prisons

Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System identifies syringe exchange as one component of "a comprehensive package for HIV prevention among drug abusers", stating that:

> Several reviews of the effectiveness of needle and syringe exchange programmes have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase into injection drug use

> or other public health dangers in the communities served. Furthermore, such programmes have shown to serve as points of contact between drug abusers and service providers, including drug abuse treatment programmes.[18] (UN, 2001)

In prisons, syringe exchange/distribution programmes have been operating successfully for more than 15 years. The first prison syringe exchange programme was established in 1991/92 in Switzerland. At present, there are programmes operating in more than 60 prisons[19]. In some of these countries, syringe exchange is available in only a few prisons, while in Spain and Kyrgyzstan syringe exchange is authorised in all prisons. Kazakhstan, Tajikistan, and Poland are all considering the implementation of pilot projects in 2005 (Lines et al., 2005; 2006).

In each of these countries, syringe exchange programmes were introduced in response to significant evidence of the risk of HIV transmission within the institutions through the sharing of syringes.

Syringe exchange programmes have proven to be an effective HIV prevention measure that reduces needle sharing, and therefore the risk of HIV and HCV transmission, among people who inject drugs and their sexual partners. As a result, many countries have implemented these programs within community settings to enable people who inject drugs to minimise their risk of contracting or transmitting HIV and HCV through needle sharing. Despite the success of these programs in the community, only a small number of countries have extended syringe exchange programmes into prisons. Those countries that have initiatied syringe exchange in prisons have been met with remarkable success. Prison syringe exchange programmes have been implemented in both men's and women's prisons, in institutions of varying sizes, in both civilian and military systems, in institutions that house prisoners in individual cells and those that house prisoners in barracks, in institutions with different security ratings, and in different forms of custody (remand and sentenced, open and closed).

Syringe exchanges were typically implemented on a pilot basis, and later expanded based on the information learned during the pilot phase. Several

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18 Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System (Approved on behalf of ACC by the High-Level Committee on programme at its first regular session of 2001, Vienna, 26–27 February, 2001). Paragraph 37.

19 www.aidslaw.ca

different methods of syringe distribution are employed, based on the specific needs and the environment of the given institution. These methods include automatic dispensing machines; hand-to-hand distribution by prison physicians/health-care staff or by external community health workers; and programs using prisoners trained as peer outreach workers.

The experiences and evidence from the six countries where prison needle exchange programs exist demonstrate that such programs:

- do not endanger staff or prisoner safety, and in fact, make prisons safer places to live and work;
- do not increase drug consumption or injecting;
- reduce risk behaviour and disease (including HIV and HCV) transmission;
- have other positive outcomes for the health of prisoners, including a drastic reduction in overdoses reported in some prisons and increased referral to drug treatment programmes;
- have been effective in a wide range of prisons; and
- have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons;
- Have successfully cohabited in prisons with other drug addiction prevention and treatment programmes (Meyenberg et al., 1999).

4.4.2 Political and moral resistance to prison based needle exchange programmes

In view of the increased spread of needle/syringe sharing and drug use in European prisons, it is necessary to raise the issue of infection risks and protection possibilities in every penal institution out of damage limitation considerations. This does not necessarily mean that syringes have to be provided or that syringe vending machines must be installed in every prison. The type of individual measures necessary for infection prevention or the choice of how syringe provision takes place (hand-to-hand or vending machine) can be made according to the needs, the structure of the prison, the prison's spatial conditions and staff capacity as well as the prisoners' culture of drug use. For instance, intravenous opiate use in parts of England, but particularly in The Netherlands, is traditionally far less widespread than, say, inhaling or smoking. Despite evidence from 15 years of syringe provision in penal institutions, the question remains unanswered as to why syringe provision in prison settings is still so controversial. Syringe provision has only

been introduced in 4 European countries to date, and even there only in specific penal institutions in aid of infection prophylaxis and harm limitation in relation to the use of illegal drugs. There is sufficient fundamental experience in, and knowledge about, syringe provision in penal institutions to justify an extensive introduction of these measures. Measures for syringe provision cannot be imposed, as the experience in Switzerland has shown, where despite an official order a number of prisons rejected them. Firstly, one must work on translating these measures into reality: all-encompassing political decisions and support to the penal institutions in practical, individual questions (legal, communicative and technical aspects) are required, to help obtain the necessary breakthrough as regards effective harm reduction in prisons (Lines et al., 2006).

4.4.3 Provision of substitution treatment

The term "substitution treatment" refers to the medically supervised treatment of individuals with opioid dependency, based on the prescription of opioid agonists such as methadone or buprenorphine (Thomas, 2001). The treatment options include the management of withdrawal on admission as a gradual detoxification (proceeding to abstinence-oriented treatment) or to long-term substitution maintenance. Substitution therapy has been widely recognized as an effective treatment for opioid dependence in the general community (Farrell et al., 2001; United Nations Office on Drugs and Crime (UNODC, UNAIDS, 2004) and as having crime reducing effects (Lind et al., 2004; Stallwitz/Stöver, 2007). Despite this and the fact that methadone and buprenorphine have just been added to WHO's Model List of Essential Medicines (2005), it remains highly controversial for prisons, particularly in eastern Europe, where substitution treatment is still prohibited in the community (Trimbos Instituut, 2007). In addition, experience has clearly shown the benefits of this treatment in prisons (World Health Organization, UNODC, 2007; Heimer et al., 2005; Dolan et al., 1998). The World Health Organisation states:

> The advantages of using substitution therapy are very great. These include reducing suicide and self-harm during withdrawal, improving regimen management problems during withdrawal and reducing the risk of fatal overdose following release from prison. The high-level endorsement by international organizations and the growing appreciation that this does work, and cost-effectively, indicates that the

> priority in the immediate future is to develop the clinical and other standards urgently required. (WHO, 2005:15)

In countries that provide methadone in prisons, it is most commonly used for short-term detoxification, and less frequently as a maintenance treatment. In some countries, such as Austria and Spain, substitution treatment is provided as standard therapy to all prisoners who began treatment in the community and are deemed likely to continue it after release (Stöver et al., 2004). In others, including Greece and Sweden, it is not available in prisons at all.

Acknowledgement that the benefits of substitution treatment in the community might also apply to the prison setting has taken years. The source of the controversy – and the slow and patchy manner of the intervention's implementation thus far – can be traced to the prison ethos of coercion, which usually manifests itself in a strict abstinence-based approach to drug use. Therefore, while opioid-dependent individuals in the community may be treated as patients and receive substitution treatment, in prison they continue to be treated as prisoners who are supposed to remain drug free. This double standard leads to frequent interruptions in treatment and inconsistency in dosages, especially as many opioid users spend periods of time incarcerated.

More than half million opioid dependent persons receive substitution therapy in the European Community (EMCDDA, 2002)[20]. In other parts of the world (e.g. eastern European) however, use of substitution therapy remains highly limited. The Position Paper from WHO, UNODC and UNAIDS (2004) on substitution maintenance therapy concludes that the provision of substitution maintenance therapy of opioid dependence is an effective HIV/AIDS prevention strategy that should be considered for implementation as soon as possible in communities at risk of HIV/AIDS. However, since the 1990s, methadone provision within prisons has expanded in many countries, for example, Canada, Australia, Poland, Iran, Indonesia, and most of Western Europe. Several studies have demonstrated that substitution treatment has become more widespread in many countries, prison administrations are considering developing standards and protocols to introduce substitution treatment, there is wider access generally, and a greater range of drugs to use in substitution programmes (Stöver et al., 2004).

20 This number has even increased to approximately 600,000 in 2006.

Evidence shows that methadone maintenance treatment (MMT) can reduce injecting risk behaviour in penal institutions such as reduced frequency of illicit drug use in prison and reduced involvement in the prison drug trade (Dolan et al., 1998). Studies have also demonstrated that methadone maintenance treatment provision in a prison healthcare setting was effective in reducing heroin use, drug injection and syringe sharing among incarcerated heroin users (Dolan et al., 2002). A sufficiently high dosage also seems to be important for an increase in the retention rate, which then can be used for additional health care services.

There is also evidence that continued MMT in prison has a beneficial impact on transferring prisoners into drug treatment after release. The initiation of MMT in prisons also contributes to a significant reduction in serious drug charges and in behaviour related to activities in the drug subculture. Offenders participating in MMT also had lower readmission rates and were readmitted at a slower rate than non-MMT patients. For example, a 2001 evaluative study of the methadone programme of the Correctional Service of Canada (CSC) concluded that participation in methadone programmes had positive post-release outcomes. The study found that opiate users accessing methadone maintenance therapy (MMT) during their incarceration were less likely to be readmitted to prison following their release – and were less likely to have committed new offences – than were those not accessing methadone. The study further concluded that:

> An important implication of these findings is that CSC may spend less money on these offenders in the long term. The cost of the institutional MMT program may be offset by the cost savings of offenders successfully remaining in the community for a longer period of time than equivalent offenders not receiving MMT. In addition, health related costs such as treatment for HIV or Hepatitis C infection would be affected by MMT availability in prisons. (Correctional Service of Canada, 2001)

Research into the subjective experiences of prisoners participating in substitution programmes reveals the heterogeneity of prescription practices in prisons. In particular, short courses of methadone detoxifications were frequently experienced as insufficient and inadequate. Most striking was the inconsistency in substitution treatment inside prison compared to the community. Forty years after the introduction of substitution treatment for opioid dependent persons its implementation is often far from adequate in prison settings. Here the availability, the implementation, clinical management, and

the evaluation of substitution treatment is often deficient (Stover et al., 2004). The practice and policy of substitution treatment differs not only from country to country, but also from state to state, and from prison to prison (Michel/Maguet, 2003). Notably, the disruption of treatment when entering the institution often leads to physical and psychological problems and increases the risk of intravenous drug use and sharing of injection equipment (Stöver et al., 2004). In 1995, prisoners in Oberschöngrün prison, in Switzerland, were enrolled in a heroin maintenance trial that coincided with a community trial and which found it was feasible to implement a heroin prescription programme in prisons (Kaufmann et al., 1997, 1998).

Substitution treatment also offers daily contact between health care services and prisoners, forming a relationship that can serve as baseline for raising further health issues and a linkage with other HIV/AIDS preventive strategy matters. It is also a central topic in preventing relapse the high mortality of drug users after release, as studies have shown that there is an increase in drug related deaths of 20–50% during the first week after release, which then slows down up to the fourth week after release (Farrell, 2005).

4.4.4 Provision of bleach and disinfectants

Many prison systems have adopted programmes that provide disinfectants such as bleach to prisoners who inject drugs as a means to disinfect injecting equipment before re-using it. According to UNAIDS in 1997, the provision of full-strength bleach to prisoners as a measure had been successfully adopted in prisons in Europe, Australia, Africa, and Central America. The WHO further reported that concerns that bleach might be used as a weapon proved unfounded, and that this 'has not happened in any prison where bleach distribution has been tried.[21]

By August 2001, bleach was provided in 11 of 23 pre-expansion EU prison systems (Stöver et al., 2004). Disinfectants are also made available to prisoners in Canada, Moldova, Turkmenistan, Iran, Kygyzstan, and some parts of the Russian Federation. Disinfection as a means of HIV prevention is of varying efficiency, and is regarded only as a secondary strategy to syringe exchange programmes (WHO, 2005). The effectiveness of disinfection procedures is also largely dependent upon the method used. Before 1993, guide-

21 Joint United Nations Programme on HIV/AIDS (UNAIDS), Prisons and AIDS: UNAIDS technical update, p. 6.

lines for syringe cleaning stipulated a method known as the '2x2x2' method. This method involved flushing injecting equipment twice with water, twice with bleach and twice with water. Research in 1993 raised doubts about the effectiveness of this method in the decontamination of used injecting equipment, and recommended new cleaning guidelines where injecting equipment should be soaked in fresh full strength bleach (5% sodium hypochlorite) for a minimum of 30 seconds (Shapshank et al., 1993).

All of these developments further complicate the effective use of bleach and disinfectants in prisons, where fear of detection by prison staff often means that drug use happens quickly, and that prisoners will often not take the time to practice optimal disinfection techniques (WHO, 2005). Furthermore bleach is effective in killing the HIV virus, but not 100% the hepatitis C virus, which can mislead prisoners into a false sense of security of having equipment cleaned efficiently. However, despite the limitations, provision of disinfectants to prisoners is an important option to reduce the risk of HIV transmission, particularly where access to sterile syringes is not available.

4.4.5 Provision of condoms, dental dams, and water-based lubricants

Condom use is internationally accepted as the most effective method for reducing the risk of the sexual transmission of HIV (WHO, 2001). As a result, many prisons across the world provide condoms to prisoners as part of their institutional health policies. As early as 1991, a World Health Organization study found that 23 of 52 prison systems surveyed provided condoms to prisoners (Canadian HIV/AIDS Legal Network, 2002). By August 2001, 18 of the 23 prison systems in the pre-expansion EU were distributing condoms (Stöver et al., 2001). Condoms are also provided in prisons in countries including Canada, Australia, Ukraine, Moldova, Estonia, Turkmenistan, Iran, some parts of Russian Federation, and a small number of the jurisdictions in the United States. This is in keeping with the recommendation of the WHO *Guidelines on HIV Infection and AIDS in Prisons* recommends that:

> Since penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should also be made available prior to any form of leave or release.[22]

22 WHO, Recommendation 20.

Despite the availability of condoms, barriers exist to their use in many prisons, and there is often poor knowledge among prisoners of sexual risk behaviour and individual risk prevention (MacDonald, 2005; Todts et al., 1997; WHO/UNAIDS/UNODC, 2007). These barriers include the fact that homosexuality is not accepted by most of the prison population and prisons do not offer enough privacy for the occurrence of this behaviour. Furthermore there is evidence that condoms, dental dams, and water-based lubricants are not easily and discreetly available, or are not available on a 24-hour basis. In many prisons, consensual sex is also prohibited, which can result in prisoners being reluctant to access safer sex measures for fear of identifying themselves as engaged in such activities.

Perkins (1998) examined the accessibility of condoms in European prisons and found a wide range of different policies '... on a continuum spanning endorsement of free distribution within prison to total prohibition.' Nine of the fifteen EU countries had clear official policies allowing free access to condoms for prisoners, in line with the WHO guidelines. The other six occupied different positions on the road towards allowing such access, from the extreme of prohibition based on lack of recognition of the problem[23]. In Scotland, Italy and Ireland, sexual relations are prohibited in prison and condoms or lubricants are not available for prisoners. They are partly handed out for home leavers and/or as part of the release pack.

In 1995 in Australia, 50 prisoners launched a legal action against the state of New South Wales (NSW) for non-provision of condoms, arguing that "[i]t is no proper part of the punishment of prisoners that their access to preventative means to protect their health is impeded". Since then, at least in part because of the legal action, the NSW government has decided to make condoms available, along several other prisons in Australia.

Studies have demonstrated the clear need to establish best practice with regards to the implementation of condoms, which requires a 'clear messages from the top about policy commitment … which needs to be reiterated through various levels of organisation' (Perkins, 1998: 34). In Austria, in July 1994 the Ministry of Justice issued the ruling that 'condoms have to be provided in such a way that unobserved taking out of a container is ensured'

23 See also Laporte 1997 who found in his European survey that in four prison systems (with a total number of of 263 prisons and about 68,000 inmates in 1996) there still was no availability of condoms at all.

(Bundesministerium für Gesundheit, 1994:2). This was viewed as another important element in successful implementation and continued use of condoms, by maintaining the confidentiality of those who wished to access them. In order to maximise HIV prevention efforts in prison, and reduce the risk of transmission via unsafe sex, condoms, dental dams, and water-based lubricants should be easily and discreetly available through a variety of distribution channels. Prisons should plan the installation of such container itself due to the circumstances inside the prison building. Experience has shown that discreet areas such as toilets, waiting rooms, workshops, or day rooms are options that increase the confidentiality of prisoners accessing condoms.

4.5 Training and engaging prison staff in implementing harm reduction services

Harm reduction measures are often perceived as threatening to the traditional abstinence oriented drug policy (Cadogan, 1999). Harm reduction often is highly politically loaded, cannot be introduced due to resistance of staff, or are perceived as inadequate for the prison setting (MacDonald, 2005). With regards to substitution treatment in prisons, this is often in conflict with the notions of prisons as 'drug free' – a notion held by both staff and prisoners. Substitution drugs are seen not as therapeutic measures, but as street drugs and prisoners often engage in dealing and misusing such substances, along with other prescription drugs (Stöver et al., 2004).

Regarding needle/syringe exchange schemes, similar objections are raised in that staff believe they will lead to an increase in intravenous drug use, an increase of accidental needle stick injuries, an increase in conflicts between prisoners or between prisoners and staff, and the risk that syringes/needles would be used as weapons or as goods within the prison economy. However, there is clear evidence that schemes have been introduced in prisons, for example in Switzerland, Spain and Germany, without these problems arising (see Stöver/Nelles). Implementing condoms in prisons is also reported to lead to security risks for staff, for example, they have been misused for drug trafficking purposes and the provision of condoms is difficult to justify to partners and families of prisoners, because it suggests that sex is common in the prison, whether is be coerced or consensual. These views and perceptions have implications in that they identify a need for training to ensure staff are

better informed of the reasons for implementing harm reduction measures, but also that they are aware of some of the difficulties that can arise.

The rationale behind harm reduction was to prevent the further spread of HIV/AIDS among prisoners, who are a particularly vulnerable group, but this also has significant implications for the health and safety of prison staff. It is essential that all prison staff receive regular training and education on HIV/AIDS/HCV prevention, infection control in the workplace, harm reduction and the needs of prisoners living with HIV/AIDS, in order to reduce the risk to themselves and others.

According to the International Labour Office's *Code* of *Practice* on *HIV/AIDS and the World* of *Work:*

> Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can contribute to the capacity of workers to protect themselves against HIV infection. It can significantly reduce HIV-related anxiety and stigmatization, minimize disruption in the workplace, and bring about attitudinal and behavioural change. (ILO, 2005: 13)

Therefore, training and education of prison staff on HIV/AIDS as well as on broader themes of harm reduction should include information to enable them to protect themselves against HIV infection though their own personal risk behaviours, education to combat HIV-related stigma and discrimination, and specific strategies related to managing HIV/AIDS in the workplace. Prison staff should also be trained in the importance of confidentiality and the privacy of medical information (MacDonald, 2005).

Training on the use of universal precautions and protective equipment as part of infection control should be provided for all employees who may come into contact with human blood or body fluids, whether as a consequence of their professional responsibilities, their working environment, or through administering first aid. The ILO further recommends that 'training [on HIV/AIDS] should be targeted at, and adapted to, the different groups being trained' (ILO, 2002:16). Training programmes need to be tailored to meet the needs of all prison staff, to fit in with their specific role and specific training should be provided to prison medical staff to ensure that their knowledge and skills are kept current with emerging medical treatments, prevention strategies and research.

Training and education on harm reduction measures should form a compulsory component of initial training for all new staff, and thereafter HIV/AIDS should be included as a component of the annual training plan in the workplace.[24] This should include education and training on existing prison policy and legislation related to HIV/AIDS, the rationales behind those laws and policies, and the duties and responsibilities of prison staff to follow them. Furthermore training should focus on the practice and philosophy of harm reduction, as this often is seen as opposing the goals of the prison sentence. Experiences have shown that participative methods are suitable and appropriate to relieve staff's anxiety. The ILO also recommends that external organisations with expertise in dealing with HIV/AIDS and other issues relating to harm reduction be invited into prisons, and it also encourages the use of peer group training, by using established staff.

Training seminars should focus on adequate behaviour patterns as part of measures initiated to prevent the spread of infections in prison. However, training which focuses on one specific risk behaviour will not be sufficient without accompanying structural changes in the prison setting. Prison staff and management can only personally identify with the objective of preventing infections if they accept that infections are a threat for everybody, both in and outside prisons, and that they have an important role in this. For example, distributing leaflet containing information on preventative measures is not enough, and they must be done in conjunction with other preventive measures such as personal counselling and healthcare awareness days for prisoners. Implementation of preventive measures is frequently jeopardized by individual attitudes and prejudice of prison staff. Moreover, prison staff often consider drug consumption a weakness of character and do not see users of those with HIV as deserving of treatment or support. Such attitudes and beliefs are deeply rooted and they cannot be changed easily. Hence training offered to prison staff should aim at familiarizing them cautiously with new attitudes and at sensitising staff towards the situation of drug-using prisoners and of course, allaying the fears of colleagues. It is also important for medical staff to be fully aware of the latest interventions and preventative strategies, particularly as they may be the only forum in which prisoners can seek help (Stöver/Trautmann, 2001).

24 Ibid.

Another important element of training is to ensure seminars focus on supporting prison staff, helping them to feel more secure in handling drug-related problems. Besides extending their knowledge on drug and drug use related issues, seminars should also answer questions related to the risk to prison staff of getting infected. For example they should be informed about post-exposure-prophylaxis (PEP) after a needle stick injury, first aid in drug-related emergencies, adequate treatment of wounds and the availability of vaccinations. Often guidelines and protocols for avoiding risk exposure and adequate safety behaviour (such as wearing gloves when searching cells etc.) do already exist. These can be used, as basic material and problems in applying these recommendations then can be discussed. Besides taking up the staff's needs and fears as an initial point of departure for training, one can use major parts of this manual for designing training seminars for prison staff.

Combining the target groups of prison staff and prisoners can be quite powerful with regard to the exchange of information and challenging existing attitudes. Exercises from the European Peer Support Manual have proved to be useful in this respect (Trautmann/Barendregt, 1994). Research has demonstrated that peer support can be a useful tool in dealing with seminars for mixed groups, and can be useful approaches to contribute to risk reduction in prisons. This would help to raise issues such as how users can contribute to training others and to implementing harm reduction measures (Stöver/Trautmann, 1998). Peer support initiatives are most successful when supported by professional or voluntary organisations (Trautmann/Barendregt, 1994), however it is important to note that in the closed setting of a prison, a risk reduction strategy would be impossible without the support of prison staff.

Chapter 5

Identifying good practice models of harm reduction in prisons

This chapter highlights the key examples of innovative practice identified from the visits to the sample countries, relating to harm reduction services within prisons and related initiatives. Although in many prisons, condoms, bleach and other basic harm reduction services were provided, the examples below highlight ways in which prison administration and prison staff often together with NGOs have overcome some of the logistical problems, and additional services that are provided for prisoners.

Implementation of harm reduction measures within prisons was seen as a key issue by many participants, as it emphasised the difficulties in working with a secure environment, with staff who are not always aware of the need for harm reduction and who often require additional training. These examples are generally indicative of innovative practice on an institutional level, rather than on national levels, as the prisons visited in the sample countries generally have control and autonomy over which strategies they employ, and how they do this.

Good practice is defined as:

> A positive action that must be successful, be innovative, have a possible multiplying effect or transference to other areas and be sustainable.

In addition, for such action to be defined as innovative, these criteria must apply to the:

- process (measures, contents, methods, approaches, tools),
- the object (new areas of interest, new social groups) or

– in the context (adaptation or improvement on the current conditions, starting-up of networks).[1]

5.1 The provision of condoms – Austria, Estonia

Austria

Along with the distribution and easy access of condoms in Austrian prisons, recent legislation and policy has also dictated that all prisons should provide easily accessible places where condoms can be taken off anonymously. In some prisons the venue is the medical unit of the prison, but it is generally viewed as more advantageous to provide this service in each section of the prison. This also extends to the availability of condoms, and recent reports of this strategy in practice show that the frequency of prisoners making use of condoms depends on the specific climate within the prison (e.g. how they are treated by staff in relation to the use of condoms). However, it is also important to address issues around the logistical problems implementing such a service, as this depends very much on ensuring staff engage and co-operate with this. It may be the case that this should be the sole responsibility of healthcare staff who can also offer sexual health advice, so the prison service are monitoring this situation, to established the best means of implementation.

It has also been observed that prisoners going on home leave make use of condoms provided by the prison more frequently, compared to those who do not make as much use of home leave provisions. It is generally believed that male prisoners are wary of being seen to use condoms within the prison as they do not want to be labelled as homosexual.

Estonia

Condoms are available throughout all prisons in Estonia, through the healthcare staff and in conjugal visit rooms within prisons. In addition, healthcare staff provide information to prisoners about why is important to use condoms, with regards to preventing the spread of sexually transmitted diseases. Through groups session with Convictus, prisoners are also able to access information about more general sexual health and family planning issues.

1 see the EQUAL Initiative website, http://www.kezenfogva.hu/equalset/

Staff based in the Ministry of Health reiterated the need for prisoners to have information as well as access to condoms:

> Condoms are available and they are being taken by the prisoners, and Convictus have an important role in training prisoners about condoms. In 2003 HIV and sexual behaviour training was also provided for the staff. Therefore, condoms are now distributed by various staff and this is seen as a successful initiative as 80,000 condoms were ordered and 50,000 were used. (Representatives from Ministry of Health, Tallinn)

5.2 Conjugal visits – Estonia, Spain

Estonia

Conjugal visits are available in Estonian prisons, and form an important part of helping prisoners maintain contact with the outside world, and also in conjunction with courses and training provided by Convictus, are useful in promoting better sexual health among prisoners. They are available to prisoners once a month, but they have to be earned through good behaviour and prisoners demonstrating that they can be trusted. Staff based in the prisons visited generally viewed conjugal visits as important for the social rehabilitation of prisoners, and their wellbeing during their sentence. Condoms are provided in the visit rooms. The rooms are spacious and self contained, so the prisoner and their partner have some privacy and time together, for example, they can cook meals in the room.

Spain

Conjugal visits are also available in Spanish and Catalynian prisons. In the visited prison of Cuatre Camins near Barcelona/Catalunyia the project is called VIS A VIS. Prisoners are allowed to receive visits two times a month for 1,5 hours. The prison aims to give prisoners the chance to maintain relationships to families and/or partners. The rooms are equipped with double bed, condoms are being laid out. Towels and bed sheets have to be brought in by partners. Shower facilities are provided. If prisoners are homosexual they may also receive visits from their partners.

5.3 Through care – Italy

Italy was selected as an example of good practice in throughcare for prisoners with problematic drug use as the drug treatment agency working in prison also works in the community and can provide continuing treatment from the community into prison and on release from prison.

In Italy since the introduction of Law 230 of the penal code introduced in 2000 drug treatment for prisoners has been provided by Ser.T (Servizio Tossicodipendehze) the community drug agency that is part of the National Health Service. Ser.T can also start drug treatment in the prison with prisoners who have had no previous contact with services in the community, and they can arrange drug treatment in the community as an alternative to a custodial sentence.

The Ser.T in Padova works with 2 prisons with 1200 prisoners of whom 30% are identified as problematic drug users, and they work with both pre-sentenced and remand prisoners. The problems that Ser.T deals with in the two prisons are very different: in the pre-sentenced prison 85% of the prisoners are migrants and approximately 85% of them are problematic drug users. Migrant prisoners pose problems for Ser.T as they have fewer opportunities for drug treatment and alternatives to prison due to their lack of citizenship and official documentation. In the sentenced prison in Padova about 30% of the prisoners are problematic drug users and only a minority of these are migrants.

The staff from Ser.T work in multidisciplinary teams of doctors, nurses, psychologists, educators and social workers. The Ser.T offers a range of treatments to prisoners with problematic drug use: increasing and decreasing methadone maintenance treatment, group support, individual psychological support, alternatives to custody for those prisoners who are eligible, information about harm reduction and drugs provided in 5 languages: Italian, English, French, Serbo-Croat and Arabic (available in prisons in Padova).

Overall, both prison staff and prisoners were positive about having Ser.T in prison and with the services that they provide. The directors of the sample prisons felt that Ser.T provided sufficient treatment but that there was also a need for more. As one official noted:

> The prison staff have good relations with the staff from SERT especially the psychologists and it is beneficial to the prison to have two extra psychologists, a doctor and a nurse for five hours per day.

5.4 Rehabilitation programmes for drug users – Bulgaria

The Prison Director at Varna Prison also emphasised the range of other programmes available to prisoners, especially those from more vulnerable groups such as drug users, those with HIV, and other marginalised groups. These programmes include social skills training, re-integration for release, assertiveness training, conflict management and more long term programmes for those with mental illness. Prisoners can also receive more practical support, such as how to deal with getting employment on release through the labour office and help with housing and financial support. These courses are particularly important as they help prisoners with problematic drug use to access social services and drug addiction services (if requested) in the community and helps them not to re-offend when they are released. Prisoners also receive basic education training, and lectures in healthcare, including HIV prevention.

There is also a 'peer to peer programme' which aims to inform prisoners about their hygiene, the regime and expectations of prison and harm reduction information. It also provides a useful forum for prisoners to give feedback about their experiences.

5.5 Partnerships with NGOs – Austria, Bulgaria, Estonia, Germany, Lithuania

Austria: Cooperation with local and regional AIDS-Help Initiatives

In order to support the harm reduction oriented activities, the Ministry of Justice has introduced recommendations for prison administration and institution staff to collaborate with regional AIDS Self–Help Groups. These groups provide:

- training and lectures for staff members and for prisoners,
- care for prisoners – no prisoners are rejected,
- Problem-oriented working with prisoners.

Another important element of recent strategy is cooperation with a counselling agency (MEN), which includes a team of psychologists and a doctor discuss important issues raised by prisoners (male only) with regard to their healthcare needs. These include general hygiene, nutrition and sexual health, and a key goal is to encourage prisoners to continue to seek this form of support on release. A similar programme for female prisoners is in development.

Bulgaria: Harm Reduction Project

A project based at Varna prison has been set up through links with an NGO (Varna Association of Non-Government Organisations for Drug Demand Reduction), to help both staff and prisoners (including drug users). It involves group sessions, individual consulting and peer support and training for security staff. It is well received by the prison staff as they recognise that it will provide an important service for prisoners, taking pressure off them to feel responsible for every aspect of prisoners' well-being. They reported that those involved on the project are very open and well aware of harm reduction issues, and also of the needs of the prison. Staff working on the project reported that it is important to train prison staff in all aspects of the work they do, in order to sustain the programme on a long term basis.

Estonia – Convictus

Convictus originated in Sweden, and was started in Estonia in 2002. It now has 25 employees of whom 50% are ex clients. They have four main projects financed largely by the global fund, with 10% from SOROS and 7% from the government. They provide:

- 15 support groups within prisons in Estonia,
- Community based needle exchange and counselling programmes,
- A support group for ex prisoners,
- A support group for women injecting drug users and for those diagnosed as HIV positive.

They are the only NGO who work constantly in prison and they have become an integral part of social work in the Estonian prison system. They are seen as experts by the prison system, and by working directly in the prison they have helped to change the attitudes of social workers and psychologists and have influenced the way they that they work with prisoners i.e. in a much more humane way.

Convictus representatives visits prisons throughout Estonia weekly, as far as possible, and during their visits they will meet with groups of 6–8 prisoners, including those in pre-trial detention and juveniles. They provide advice on healthcare and harm reduction services for problematic drug and alcohol users, and offer links to community services, to provide through-care services. They also have a contract with the Family Planning Programme who have been seeing around 10 prisoners in each of their group meetings (with

two groups per week over the last 6 to 12 months). The groups are offered in both the Estonian and Russian languages. Prisoners hear about the Convictus groups from each other and then they have to write an application to join the group. Convictus also hold information days, to reach more prisoners at one time which is also important for those on short sentences, who cannot wait until they can join a group meeting. Convictus staff are also important in training prison staff and making them aware of the needs of prisoners who use drugs, or who are HIV positive, such as now, the prison services no longer separates HIV positive prisoners, so they are less likely to be stigmatised.

They are also vital in addressing the needs of more vulnerable prisoners such as those in pre-trial detention, who do not have access to education, work or treatment services, and those diagnosed with infectious diseases, such as HIV, hepatitis and tuberculosis. Convictus have also been asked to work at Viljandi and Tartu prison with those under 18 years as they have different needs and they are also hard to work with. Convictus offer expertise and support to prisoners which they may not feel able to seek elsewhere, due to concerns about being judged or not being treated humanely, as described by a female prisoner:

> Convictus come into the prison and they were really helpful, as they reassured me that there are people who care and will treat me as 'normal'. (Female Prisoner, Focus Group, Harku Prison)

Generally, prisoners reported that they value the service provided by Convictus, which was reiterated by staff based in the Ministry of Health:

> They meet the different needs of many different groups, including those leaving the prison, who have no other means of support. (Representatives from Ministry of Health, Tallinn)

Germany – working with NGOs

In the two prisons visited in Lower- Saxony NGOs have mainly been integrated in the prevention work against HIV/AIDS and other blood-borne viruses. In the women's prison of Vechta an organisation calles "Junkies/Ex-User/Substitutees (JES) is coming into the prison monthly in order to contact women with a drug using background. These group meetings focus on:

- awareness raising regarding risk behaviour in prisons,
- stimulating an exchange of knowledge and experiences,

- dissemination of prevention material,
- safer use training,
- advice for general problems.

The prison has a longstanding contact with JES, dating back to the times when the prison held a needle exchange project (1996–2002). The advantage of this NGO-work lies in authentic transport of prevention and harm reduction messages, because the group members themselves have experiences of using drugs and of serving prison sentences.

In the men's prison of Gross-Hesepe the local AIDS-Hilfe Emsland, visits the prison bi-monthly and offers an afternoon for interested detainees. This cooperation also dates back the introduction of a needle exchange project (1996–2002). The longstanding cooperation between prison and NGO is acknowledged by representatives of both. The group meeting focuses on all aspects of living at risk in the prison setting and how to reduce harm, such as:

- sexual contacts (men having sex with men),
- intravenous drug use,
- effective cleaning of needles and syringes,
- dissemination of material,
- support in everyday life matters.

The harm reduction work of the NGO is an integral part of the prisons' work on the prevention of drug use and HIV/Hepatitis/STI transmission.

Lithuania – working with NGOs

The prison service has a link with an NGO, called 'Space of Life', which is a rehab centre for problematic drug users, based in Kaunas. It organises group therapy for prisoners (who are motivated to cease drug use) and also provides social care after release. Staff in the NGO believe prisoners are more willing to participate in programmes in the community which are run by NGOs, compared to prison based programmes. They are also working hard to address the link between injecting drug use and HIV, through active participation in National Programme of Drug Prevention and Control, which includes infectious disease prevention (including sexually transmitted diseases). This programme operates on a national level and throughout the whole prison system and also does preventative work in schools and colleges to educate younger generations.

These have been set up as therapeutic groups, using current and former prisoners and problematic drug users to educate others about the risks of infection, and how to maintain their health. They are trained through links with NGOs and community based treatment services (such as 'Space of Life' and Alcoholics Anonymous and Narcotics Anonymous services). An important part of this is to invite former prisoners as examples of how it is possible to cease drug and/or alcohol use, get a job and start again after imprisonment and drug use. Many prisoners are worried about the stigma of prison, and feel that they will be unable to get help with housing and employment, or that they will use drugs again. Therefore to meet with those who have successfully re-joined society is an important step towards rehabilitation.

A consultant from the AA/NA (Alcoholics Anonymous and Narcotics Anonymous) groups has set up meetings with female prisoners at Panavesky prison, to help them in ceasing drug and/or alcohol use, but also to train prisoners to act as peer group educators. They emphasised the need to pass on good practice:

> After being free from alcohol for 6 months, I wanted to pass on my success and so I introduced my services to the prison 10 years ago – it started with very few meetings, but it has now built up to more regular sessions and many being run by prisoners themselves, throughout Lithuania. (AA/NA Consultant)

This has received very good co-operation from the staff at Panavesky prison and the national prison administration, and it also contributes to pre-release integration programme. In training prisoners, it aims to make all the groups independent and continuous in the prison, so if voluntary NGO staff do not turn up the group can run itself and members of the group are also encouraged to continue meeting up, particularly when they are released, if this is possible.

5.6 HIV education through peer groups and NGOs – Romania, Spain

The Development of HIV/AIDS Interventions in Romanian Prisons

Romania was selected as an example of good practice in the use of peer groups as part of HIV/AIDS interventions in prisons. The Romanian Prison Service Department has forty-three prison institutions including thirty-four prisons, six prison hospitals and three centres for young offenders. Harm

reduction is an important area for the Romanian Prison Service Department to consider as statistics from the Ministry of Health and Family show that 9,928 HIV and AIDS cases were recorded in the community with most of them being teenagers (December 31, 2002). In addition, the incidence of other infectious diseases within the prison system is generally high.

The philosophy behind the HIV/AIDS interventions in the Romanian prison system is that:

> For some prisoners, being in prison presents an opportunity to become better informed about health care, through participation in programmes designed to increase their knowledge and awareness of HIV/STIs. An anticipated outcome is that those prisoners who do engage with the health education programmes are less likely to engage in risk behaviour upon their release thus posing a lesser threat to the wider society. But also whilst in prison, they have a key role to play in increasing the health status inside prison. Those who have undertaken training with specialist staff, and who possess good communication skills, are able to act as peer health education advisors, disseminating correct information on HIV prevention to their fellow prisoners. One of the characteristics of prison life is the hierarchical structure among prisoners. Inside this structure, "waterfall education" via peer educators is very effective in the transmission of a message. (Qaramah and Parausanu, 2005:277)

The education programme for prisoners with problematic drug use involves information about how to reduce the possibility of diseases via sharing needles, along with various programmes about drug use and the associated risks. Due to the high turnover of prisoners, staff working on the project reported that it was not always possible to discuss topic in depth, but that they managed at the very least to give them all leaflets. Staff involved in the programme considered it to be particularly important to pay special attention to juvenile prisoners. A key part of the programme is using prisoners to act as peer educators, to inform other prisoners about the correct use of condoms and needles and to provide information about needle exchanges in the community. Prisoners from the focus group (Colibash Prison Hospital) were on the whole positive about the harm reduction information that they received:

> I may stay at the hospital for 2 weeks and the information provided is well done. In large prisons you don't get this harm reduction information. I am happy in this hospital as both medical and security staff are good.

In Giurgiu Prison there are 299 drug users, most of whom are injecting drug users and under 18 years old. The Peer educators in the prison aim to raise awareness and also to answer questions about HIV and drugs and they work with small groups of 10–12 prisoners, using free discussion and profiling sessions. The peer educators are not necessarily former drug users. Giurgiu was the first prison to start the peer educator project and they now act as the resource centre for other prisons:

> During the first training session with prisoners we discussed with them about the prisoners living with HIV, homosexuality and drug users. The prisoners' first reaction was that 'we will cut their throat if they come here'. By 2004–5 the level of acceptance of these groups by other prisoners has increased dramatically. Training session were done with staff and prisoners and when ANA [community drug agency] came here they found a good change in attitudes. We started this work 6 years ago and were met with inertia but we have grown a lot now. Peer educators are rewarded with commendations, extra packages and visits.

In addition to the peer educator programme most prisoners get harm reduction leaflets, magazines and information from television, as well as from community health and drug services (ANA) who also work in partnership with the prison. In order to promote harm reduction staff in the prison also have meetings to raise prisoners' awareness about drug use and related issues, and organise art competitions where prisoners receive certificates (these are attached to prisoners' records). These discussions also impact on other prisoners who share rooms with those attending the sessions as the information is passed on. However, one problem that was raised by staff is that the peer educators keep getting transferred to other prisons or are released. The staff raised the issue that it was very important that senior prison management support the peer education project to ensure its success and sustainability.

Although the HIV/AIDS intervention programme and the use of peer educators was seen as useful by prison staff and prisoners many prisoners stressed the need for treatment programmes and healthcare services for drug users:

> It is good to have peer educators who used to be dealers or users advising others not to try drugs. I also want treatment as I was on heroin for 7 years and I lost my teeth and this happens to many others.

> Some of us have Hepatitis C and mental problems and all we are given are sedatives.

The work of the peer education programme not only informs and changes attitudes of prisoners and staff but also when prisoners return to their communities they have increased knowledge of how to protect themselves and can share this information with their friends and families.

Peers for Health (Mediadores en salud) in Spain

External NGOs collaborate with Spanish (including Catalan) prisons in providing health education for prisoners. They also work with the central administration staff to follow up the outcomes of such programmes, for example peer educators providing information on healthcare, to measure their success. The key stages of this process are:

Creation of the Peers for Health Education Team in the prison, formed by doctor, nurse, psychologist, social educator, social worker, teachers and security staff of the prison, as well as NGO members. Training of the team, by an external entity (NGO) with previous experience and technical skills. At the end of the training, a "Healh Education Project" is ellaborated. The team makes the selection of the prisoners and their training as "Health agents". The Team and the Health Mediators design and implement the activities of information, awareness and health education with the prisoners, adapted to every prison.

During 2005, 15,892 prisoners (of all but the Catalan prisons) participated in these activities[2]. The NGOs train and assess the staff of the prison, and they also work directly with the prisoners, training them to be peer educators. The contents of the education are varied, for example, they can include information on HIV, HCV and TBC prevention, safer sex, safer use of drugs, including safer injecting, hygiene, diet and laughter therapy. Every centre runs the program according to its own characteristics (and the characteristics of the prisoners), and they usually apply more than one methodology, including workshops with the peers and/or individual assessment. These programs are directed and financed by the General Directorate of Penitentiary Institutions, with the financial aid of the National Plan against AIDS (Health Ministry)[3].

2 Sanz et al. *op. cit*.

3 General Directorate of Penitentiary Institutions, Ministry of Interior, Spain.

In Catalunya, the AIDS program of the Health Department finances four NGOs to help them with developing several programs in seven Catalan prisons. There are different kinds of programs, such as health education, emotional support, adherence to antiretroviral treatment, and intra/extra penitentiary coordination of sanitary services for HIV infected prisoners who are on antiretroviral treatment. These programs are either provided on an individual basis (e.g. one to one emotional support, intra/extra penitentiary coordination) or group sessions. These sessions take place either in the residence departments of the prison, in the department where the prisoners stay the first 24 hours, or in the Infirmary area.

5.7 Substitution treatment – Austria, Spain, Poland

Substitution treatment in Austria

The basic goal of the Austrian prison policy is to provide prisoners with an access to health care services, which includes substitution treatment. According to recent studies, 20–60% of prisoners are identified as problematic drug users, which is explained by the high prevalence of crimes and offences in the context of substance use. At the time of the visit, there were 650 prisoners under substitution treatment (7,2 % of all prisoners). The treatment is offered in all prisons and not limited to the duration of sentence.

The use of drugs in prison which is widely documented, increases the incidence of other high risk behaviours, such as sharing injecting equipment and overdosing. To address these issues requires an appropriate response, such as substitution treatment, which has become a standard therapy in custody. On the one hand this serves as measure demand reduction and on the other hand it serves the function of stabilization of health for chronic addicted prisoners. The provision of substitution treatment stems from orders of the Ministry of Justice, which states that it should be available in every Austrian prison.

Improvement of substitution treatment in Spain[4]

In the community (Spain including Catalunya), 90,488 persons were treated with methadone in 2002, and 88,700 in 2003[5]. In Catalunya, the number of active cases in Methadone treatment were 8,455 (March 31st 2005)[6].

4 Data comes from an on-going review of research reports, websites and laws/regulations, as well as from interviews conducted during the field visit.

All prisons in Spain offer initiation of methadone, methadone maintenance treatment, and detoxification with methadone. Brief and progressive detoxification may also be offered with opiates and benzodiazepines. Substitution treatment in prison has been developed as part of the harm reduction strategy since 1992, and was extended to all prisons in 1998. Articles of the Spanish Constitution of 6 December 1978 underline the equivalence of health care between the community and the prison. The General Health law of 14/86, of 25 April, further states prisoners' rights to access health services similar to those offered in the community. The circular 5/95 from the directorate general of prison services on the global drugs policy 5/95 establishes that within the framework established by the National Drugs Plan (Plan Nacional sobre Drogas), in coordination with other sectors of public administration or other organisations and institutions, such as the Municipal and Regional Drugs Plans (Planes Autonómicos y Municipales sobre Drogas) and Non-Governmental Organisations and Entities, prisons will run specialised drug dependency programmes for prisoners who voluntarily request them, consisting of prevention, harm and risk reduction, methadone treatment, breaking the cycle of drug dependency and social reintegration.

Health care in prison is under the management of the Ministry of Interior (Directorate General of Prison Services). Substitution treatment is offered in prison as part of 'interventions' for drug using prisoners. The objectives are to reduce of deaths due to overdose; to control and reduction of physical health harm; to control or reduction of infections like HIV; to reduce of delinquent activity and recidivism; to improve social and labour adaptability; to modify drug use; to provide a means to remain abstinent for several periods and to improve and facilitate rehabilitation and reintegration into social life (Ministry of Interior, 2001).

The only inclusion criterion is the confirmed diagnostic of opioid-dependence. The prisoner receives information about the finality of the treatment, its risks and consequences. The information is given in comprehensible terms, complete and continuously, oral and also written. Methadone is offered as treatment with methadone (methadone treatment), or a treatment of detoxification with methadone. These two types of treatment are not

5 National Plan Against Aids, http://www.pnsd.msc.es/Categoria2/publica/pdf/ memo2003.pdf

6 General Directorate of Public Health, http://www.gencat.net/salut/depsan/units/sanitat/pdf/si1rtr05.pdf

exclusive. A prisoner may go from one to the other, according to the biopsychosocial situation of the drug user. To reach efficacy, the biopsychosocial focus needs to be part of a drug user's treatment. Methadone programmes must include health interventions, psychosocial interventions (with group and individual therapeutic sessions) and throughcare (or preparation for release and rehabilitation).

The Ministry of Interior (2001) reported that methadone treatment is the most effective intervention for the number of drug using prisoners it attracts, and for individual and group benefits it brings. Moreover, it facilitates the reduction of drug use, reduces the intravenous use of drugs, improves physical and mental health, as well as hygiene and health habits. It reduces antisocial activities, delinquent activity and recidivism (and return to prison) and quality of life is generally improved. The Ministry of Interior (2001) stated that in order to reach all these advantages and benefits, methadone treatment cannot be limited to the sole prescription and distribution of the substance. Methadone must be delivered within a global therapeutic approach, taking into account individual differences and needs, and including psychological and social interventions. A sole distribution of methadone is a harm reduction measure, contrary to a methadone treatment that includes psychosocial activities and preparation for release (and, if needed, continuation of the treatment on release in a community centre) and is thus a rehabilitation treatment. Detoxification treatment with methadone is offered to drug-using prisoners who wish to abstain from drugs and according to their health, personal, social, penal and penitentiary conditions. In 2005, 8,080, (15.32% of the total prison population) participated in methadone maintenance programmes (Ministry of Interior 2001).

In summary the following criteria of good practice of substitution treatment in Spanish prisons can be noted:

- Same inclusion criteria than outside in the community.
- No waiting list.
- Smooth transition from in prison programme to outside.
- Integral part of a comprehensive drug strategy including needle exchange, drug free treatment, access to HAART.
- No exclusion with other programmes (except drug free Therapeutic Communities).

Substitution treatment in Poland

The basic problem in introducing substitution treatment in prison is the fact that this treatment is not available across the whole of Poland. This has caused problems of delay in introducing this treatment because it cannot be guaranteed that prisoners will be able to continue their treatment in the community once released. This is the key argument of experts and practitioners from the outside who argue that it is only justified to provide substitution treatment if it is possible to continue it in the community.

Negotiations from Polish Prison Administration with community representatives have led to the fact that substitution treatment programmes have been established at least in some prisons. The Kraków Remand Prison Montelupich prison is one example, where, prior to the methadone programme being established, there was extensive negotiation with the community providers of the methadone programme and thorough training of prison staff. The main problem with the implementation of the methadone programme in prison is the lack of a national strategy. For example, when participants in the pre-trial prison are sent to other prisons in Poland, the continuation of the treatment is unlikely or impossible but they will be definitely detoxified (see Stöver et al., 2004).

Despite these difficult circumstances more programmes have been started in pre-trial institutions in Warsaw (April 2004; personal communication Wojciech Rudalski, 2007). The *NOVA-Methadone Substitution Programme* is aimed at opiate dependents, imprisoned in Warsaw penitentiary institutions – Remand Prison Warsaw-Mokotów, Remand Prison Warsaw-Białołęka and Remand Prison Warsaw – Służewiec. The number of participants was set at a maximum of 15 people per year. It is intended to be an extension of the available health services for imprisoned dependent drug users and is planned to continue for many years. The duration of individual cases will depend on the level of the patient's rehabilitation. The programme will be implemented in close cooperation with existing external methadone programmes (including The Institute of Psychiatry and Neurology in Warsaw, the Judicial Psychiatry Ward of the Prison Hospital in Remand Prison Warsaw-Mokotów, the National AIDS Centre and the Drug Prevention Office). The programme offers an alternative to imprisoned drug users where other methods of treatment have failed.

The programme is targeted towards individual gains for each participant. It will allow them easy access to reliable medical, psychological and therapeu-

tic information and thereby influence social attitudes and education regarding moral, social and health issues. In the NOVA programme, Methadone is used as a medium for improving the contact with a drug dependent prisoner, which in turn offers the possibility for psychological stabilisation, the treatment of HIV infections and other serious diseases, improving the somatic state and achieving desirable socialisation and psychological goals.

In the first 24 hours of his stay, a doctor will examine every opiate-dependent patient brought to the remand prison in order to evaluate his psychological and somatic state. If the patient meets the qualification requirements, set by the Polish Ministry of Health and Social Care in a separate decree, the programme director will accept the individual into the programme and inform the proxy of the prison service regional director. Additionally, the participant must have prisoner status. For a new patient, the possibility of continued methadone substitution treatment, after leaving the penitentiary institution, must be secured before they can start the programme. However, in special cases, the doctor can waive this requirement for health reasons.

The fundamental principle of the NOVA programme, is the complete freedom to take part in it. The patient may voluntarily opt out of methadone substitution treatment. In such a situation, in outreach conditions or in the prison hospital, a gradual detoxification is administered, with the use of methadone, until complete abstinence is reached. Should complications appear, it is possible to hospitalise the patient in the following Wards: Internal Diseases, Intensive Care and Psychiatric, as well as other wards of the Prison Hospital of the Remand Prison Warsaw-Mokotów.

Participants in the programme are provided medical care, centred on the diagnosis and treatment of infections and illnesses connected with intravenous drug use (HIV, HBV, HCV, bacterial infections, thrombotic vein inflammation), as well as others including tuberculosis, venereal diseases and mental disorders. If required, prisoners may ask for consultation and care from the HIV/AIDS consultant, the contagious diseases consultant and other specialists employed by the ambulance and the hospital in the Warsaw-Mokotów prison and in the ambulance of other prison institutions where the programme will take place. Those people who do not agree to protracted methadone therapy after leaving prison will undergo gradual detoxification during their stay in the prison and, when they leave, they will be directed to institutions offering rehabilitation for addicts.

The NOVA programme is a form of protracted methadone substitution therapy. However, after the patient leaves the penitentiary unit they continue substitution therapy in their area of residence on a voluntary basis. For that reason, only those patients who, due to where they live, gain a guarantee of continued substitution treatment (in both existing and newly created methadone programmes country wide), will qualify under the first part. Finding such a places for patients in external programmes will be among the duties of NOVA staff.

As mentioned previously, it is critical to consider methadone substitution as an extension of prison service healthcare for opiate-dependent prisoners. They provide continued treatment for some and offer a chance for those who have not met the requirements of other methods. We cannot forget that drug users are an inseparable part of the community, even if they are, at present, isolated from it. The most recent changes concern issues of MMT – the Polish Prison Administration has started a new program in the remand prison of Poznan and they have expanded the one already existing and visited during the research in the remand prison of Lublin for the rest of penitentiary institutions in Lublin Districts (7 in total).

5.8 Prison based needle exchange programmes in Spain

As an example of the implementation process via protocols and frameworks the introduction process of needle exchange in Spanish prisons should be mentioned. Following the positive experience of these projects, the Spanish government made a commitment to expand their availability and in March 2001 the parliament approved a green paper recommending the implementation of needle exchange programs in all prisons. From this point, events moved quite rapidly. In June 2001 the Directorate General for Prisons issued a directive requiring the implementation of needle exchange programs in all prisons. This was followed in October by a directive from the Subdirectorate General for Prison Health specifying that needle exchange programs should be introduced in all prisons by January 2002. In March 2002 the Ministry of the Interior and the Ministry of Health and Consumer Affairs jointly published the document Needle Exchange in Prison: Framework Program, which provides the prisons with guidelines, policies, and procedures, and training and evaluation materials for implementing needle exchange programs.

With these guidelines, every prison elaborates its own needle exchange program. In order to elaborate, implement, follow up and evaluate the program, 1) a Commission is created, with the Director and vice directors (including sanitary vice director) and representatives of security staff of the prison, as well as representatives of the Drug Dependence and Aids Regional Programs. They 2) study the needs of the prisoners, analysing iv drug use (number of drug users, frequency of drug use, and drugs used), 3) elaborate the norms of the program, 4) analyze the opinions and attitudes of prisoners and penitentiary staff, 5) determine the strategies of implementation and 6) establish the items for the evaluation.

The negotiation process in Catalunya

In Catalunya, the General Directorate of Drug Dependence and Aids worked together with the General Directorate of Penitentiary Institutions collaborating since 1991 to improve the healthcare of drug users. Both wrote the "Needle Exchange in Catalan Penitenciary Centers: Framework Program". In this framework program, the program was justified, introduced and its implementation in the Penitentiary Centre of Tarragona was foreseen, as a pilot project, the spreading of the program to other prisons depending on its evaluation and results. The Framework Program was then sent to Tarragona, where it was adapted and completed, and returned to the General Directorate of Penitentiary Institutions, where it was again supervised and accepted.

If we compare the Framework Program with the first pilot project of the program, in Tarragona, we will see a few differences. Firstly, the Framework Program gives more importance to the theoretical aspects, justification and research: methodology of needle exchange in the context of harm reduction, different research evaluation of needle exchange programs in the community worldwide, development of needle exchange in the community in Catalunya, health risks in the penitentiary institutions (including high rates of HIV prevalence, IV drug use, etc.) and the development of healthcare for drug dependents (including the introduction of needle exchange programs), as well as the WHO directives on HIV infection and aids in prisons. It includes a bibliography of 47 references (for the 10 first pages of the program). And secondly, it details the previous conditions for the implementation of the

needle exchange program in penitentiary institutions, such as juridical and technical aspects, that are not mentioned in the Tarragona program[7].

On the other hand, the Tarragona version of this global program only includes a paragraph with the methodology and justification, with no references at all, but goes into detail in the practical aspects of the implementation, including aspects that are not developed in the framework program: details abut the time of the first and the following deliveries, and a protocol of the steps to be followed since the inmate asks for a syringe. It also includes many annexes: the Behaviour Compromise (or consent) to be signed by the inmate (accepting the norms of the program), that is identical to the one proposed in the framework program, but also many other annexes, that were not included in the framework program: Data of the prisoner (to be filled at the beginning of the program, including age, department, intravenous drug use, health data, needle related data); first and following delivery paper; evaluation and final conclusions on the needle exchange program by the inmate; training proposals for the personal staff of the prison (for sanitary, treatment and security staff and also specific training for sanitary and treatment staff)[8].

5.9 Testing and treatment for communicable diseases – Austria, Lithuania

Austria

Every prisoner has the opportunity to get a blood analysis done, to determine their health status. However, an evaluation of the data regarding HIV/AIDS/ HEP B und C in Austrian prisons in 2000–2001 shows, that the amount of HIV-tested persons varies considerably between 0–100%. This variation is supposed to be critical, because every detainee should have the opportunity to have access to a HIV-antibody test. In every case pre- and post test counseling is supposed to be a standard for any procedure (Pont, 2002). Pre-test counseling includes the transport of information re anonymity and voluntariness of the test as well as information regarding infectiosity and possible transmission to others. He or she will be informed about programmes aimed at drug abstinence and risk reduction and will then be informed about possi-

7 Needle Exchange in Catalan Penitentiary Centres: Framework Program. General Directory of Penitentiary Institutions and General Directorate of Drug dependence and AIDS.

8 Needle Exchange Program in the Penitentiary Centre of Tarragona.

bilities of vaccination programmes. The post-test-counselling includes all necessary examinations, pharmacological treatments and the prognosis within the context and suppositions of the institution. Vaccination programmes are foreseen in all Austrian prisons.

Lithuania – testing for communicable diseases

The Head of the Medical Division in Prison Department in Lithuania emphasised that the lessons from the Alytus Prison outbreak in 2002 have been learnt, such as to get better information on prevalence of infectious diseases, stages of infection and the symptoms presented, for HIV, Hepatitis B and C and tuberculosis among the prison population. This also acted as the impetus for introducing condoms and bleach, as the prison service was forced to acknowledge the problems faced with regards to drug use and sex.

5.10 Training for healthcare staff – Germany

Every doctor involved in substitution treatment has to undergo a special course called addiction medicine – basic provisions (Bundesärztekammer, 1999). The Federal Medical Association has elaborated a 50 hour course which doctors have to undergo before they get involved in prescribing substitution agents. This counts for prison doctors as well. The curriculum of the course foresees an improvement of addiction specific knowledge, a challenge and assessment of the attitude towards addicted persons, improvement of psycho-social competencies of the doctor to make use of the resources of the patient and the ability to co-operate with non-medical professions. It is not solely directed towards the prescription of opiates but it is addressing all relevant drugs and addictions. The basic method taught is motivational interviewing, which is suggested to be applied in the dialogue with dependent patients.

5.11 The provision of bleach – Austria

In all 28 Austrian prisons anonymous access (in most parts) to disinfectants in order to avoid the transmission of BBVs via sharing of needles and equipment is achieved. The Austrian Ministry of Justice pointed in several orders (Erlass) that beside condoms, the disinfectant Betaisadona should be made available freely and anonymously in all prisons. The primary purpose is the cleaning of injection equipment and the treatment of injection punc-

tures. In this context the target group are not only drug users but also those prisoners involved in tattooing. The implementation of this order varies from prison to prison. According to some experts the opportunity to do so is given in others not. One of the main reasons justifying not giving betaisadona to the prisoners is the scarcity of personnel and their work overload. The prisoners make use of this in different ways, however there is some resistance, for example drug users fear detection by security staff and those engaging in tattooing, for similar reasons, as they will be punished.

5.12 The provision of hygienic packs – Austria, Spain

Hygienic Pack "take care" in Austria

The increase in the number of drug addicted prisoners, persons in danger of getting addicted, persons with a co-morbidity, and prisoners with a poor general health status have led to the introduction of harm reduction measures in Austria prisons. Increasing incidences of tattooing, the exchange of injection equipment, sexual activity and the high prevalence of infectious diseases were the rationale behind providing prisoners with a 'Take-Care-Package'. The purpose was to protect those prisoners engaged in high risk behaviour. In 1997 the prison of Vienna Favoriten applied to the Ministry of Justice to be a central site for distributing information material to the topic of HIV/ AIDS/HBV/HCV prophylaxis and condoms. The 'Take Care-Packages' can be ordered by every institution from the prison of Vienna Favoriten (production done by a social therapeutic working project for women called "Nora"). The information material is also available in several other languages: Albanian, Arabic, English, Finnish, French, Greek, Italian, Croatian, Serbian-Croatian, Polish, Portuguese, Romanian, Russian, Slovenian, Spanish, Czech, Turkish and Hungarian.

Hygienic Pack (Spain)

In the prison visited hygienic packs were given to the prisoners, which can be refilled. These packs are consisting of: 2 rolls of toilet paper, shower gel, Shampoo, 2 handkerchiefs, 3 condoms, deodorant, toothpaste, shaving cream, soap, comb, toothbrush, knife, fork, spoon, 3 shavers, sponge and a dish. The hygiene pack was seen both by prisoners and by staff as an essential prerequisite for addressing hygiene to be an important issue for all prisoners. It was said by both groups that it serves as an 'appetizer' for talking about health issues.

Chapter 6

Barriers to the implementation of harm reduction in prisons and requirements to ensure sustainability

The following chapter outlines the key requirements needed in order to successfully implement sustainable harm reduction services in prisons. As the good practice examples above demonstrate, it is possible to overcome barriers to implementing harm reduction measures, it is important to acknowledge the requirements that need to be in place to overcome the various problems that occur. There are certain requirements that need to be formulated at all relevant levels: attitude towards and knowledge about harm reduction, drug addiction and health risks for all key actors, necessary changes both at the policy and practice level. These guidelines are formulated from evidence-based practice, as opposed to moral and value judgements. Previous research highlighted in chapter 4 has demonstrated that harm reduction interventions are already well established and well evaluated in prisons and the wider community, providing a firm foundation for other countries and prison administrations to further develop their own interventions.

6.1 Overcoming institutional challenges

Despite obvious damaging health risks for prisoners and prison staff (Bögemann, 2007) the obstacles to and arguments against change within prisons have remained disturbingly constant through the years (Stöver/Lines, 2006). Prisons are by definition places of secure custody and this security-based ethos infuses policy in all areas of prison life, including the provision of health care. Therefore experts stress the necessity to regard prisoners also as patients (Coyle, 2007) with specific and defined ethical basis (Restellini, 2007; Hayton, 2007). Prisons are also rooted in a culture of surveillance, in which prohibitionist approaches towards drug use are even more firmly entrenched than in the outside community. Both of these characteristics are

sources of resistance to the implementation of harm reduction measures, effects prevention, treatment, care and support. The security-based ethos has meant that prison systems have traditionally viewed health threats from a perspective of institutional security, rather than from one rooted in health care or human rights. As a result, prisoners living with HCV, TB or HIV/AIDS, drug users have often been dealt with as security risks to be contained and controlled, rather than individuals in need of compassionate and specialized health services. The most blatant manifestations of this coercive approach have been policies of mandatory HIV testing and of isolating HIV-positive prisoners.

While such policies have been largely – but by no means totally – eliminated in European prisons in favour of voluntary testing and integration, the attitudes underlying them remain in force. According to this coercive security-based ethos, syringes, condoms[1] and bleach are seen only as potential weapons and or instruments for criminal behaviour. Requests by prisoners living with HIV/AIDS for pain medication to relieve what is often severe HIV-related chronic pain are regarded as 'drug-seeking behaviour'. The provision of substitution treatment is seen as undermining abstinence-based approaches to drug use. And the compassionate release of terminally ill prisoners living with HIV/AIDS is considered a security risk to the community outside.

A recent study found that security constraints common to most prisons may lead health care workers to engage in risky behaviours that increased their risk of blood-borne infections. The study found that nearly 29 percent of correctional health care workers "frequently or always" recapped used needles – that is, replaced the needles' protective plastic cap – a behaviour that greatly increased their chances of getting pricked by a contaminated needle. The report suggested that the high rate of needle recapping among correctional health care workers was due in part to having to keep used-needle containers locked away in secure rooms. Similarly, the researchers found that hand washing rates were below average among correctional health care workers, and laid some of the blame on prison employees' diminished access to sinks and soap in the prisons (Stöver/Lines, 2006).

1 To hide drugs in the body.

6.2 Overcoming abstinence orientation as pre-dominant response

One important obstacle for not introducing harm reduction measures in prisons is the basic *abstinence-orientation* to be found in many prison visits throughout the research. This accounts not only for doctors, nurses and other responsible persons in the prison service but for prisoners themselves. This goal is identical with the goal of the sentence itself (to enable prisoners to live a life without committing criminal offences, i.e. drug consumption, dealing). Despite the fact that drug use occurs in prisons and where the consequences to health are clearly visible, the goal of abstinence remains, and is encourages at the expense of considering other goals, such as methadone maintenance for those who do not wish to cease using drugs during prison, and syringe exchange programmes to prevent the spread of communicable diseases. Harm reduction measures are seen in the model of prison as a time of abstinence as conflicting with the needs of prisoners and staff, and also as condoning criminal activity within a criminal justice setting. Several interviewees feared that dealing with the reality of drug use in prisons and designing harm reduction measures would be the wrong signal leading to an affirmation of drug use.

The reasons for resistance against the introduction of harm reduction measures for prisoners are manifold, but basically to be found in the very structure of closed settings like prisons:

- fear of being known as a drug user/addict,
- fear of losing privileges,
- fear of not getting onto work or qualification programmes,
- fear of partners, family and relatives knowing they are using drugs in prisons.

Abstinence orientation requires systematic approaches to achieve and/or maintain abstention from drug use in prison or reduce harmful drug using patterns:

- Providing standards and diversity of drug services in prisons to match those available outside of prisons.
- Counselling on drug and HIV/AIDS-related issues (provided by prison staff or specialised personnel, integration of external drug services).
- Housing of drug using prisoners in specialised units with a treatment approach and multidisciplinary staff.
- Provision of voluntary drug-free living units.

- Provision of print media and audio-visual material (in different languages, and including the involvement of counselling agencies from outside the prison in the production of this material).

However, it should be accepted that it is often unrealistic to expect drug-using prisoners to change their behaviour drastically and sustain that change while in detention (i.e., to live drug free). Providing services to drug-users in detention is designed to give them an idea of a realistic and alternative life-style, and assist them to raise and strengthen self-motivation and feelings of responsibility and to accept changes only occur gradually. Providing a variety of aids that help drug-users to become aware of alternatives must support these attempts.

6.3 Information, education and communication

Changes in the attitude regarding drug addiction, HIV-positive prisoners and people living with HIV/AIDS can first be initiated by extensive programmes of information, education and improvements in communication. Transparency is the key word to be communicated for all relevant status groups.

Prisons are institutions characterized by a coercive and punitive ethos which is reinforced both by the institution and also by the prison subcultures. Prisons are also environments in which new and probably unexpected risks are presented for prisoners that they may not have faced when living in the community (i.e. clandestine and quick drug use with shared needles, sexual contacts with the risks of being discovered either by other prisoners or staff, rape or other non-consensual sex, tattooing with contaminated needles). For some, prison is the place where they first begin injecting drugs, take new and probably risky mixtures of drugs, while for others it is used as an opportunity to reduce or even stop their drug use.

Prevention programmes with a harm reduction orientation must therefore reflect these particular conditions and individual responses and behaviour in order to be effective. Community-based strategies cannot simply be transferred into the prison setting without responding to the particularities of the risk environments and the limitations available for behaviour change (lack of access to sterile syringes, for example). If prevention messages are to be accessible and relevant to the target group, specific living and risk conditions must be identified and preventions strategies tailored to these circumstances and different target groups (Stöver/Lines, 2006).

The use of modern educational methods (e.g. interactive methods) and of visual aids is now well established. Seminars directed to a better understanding of problematic or risk behaviour will produce more effective collaboration between prisoners and staffs in reducing the spread of HIV. Involving drug users in developing, designing and delivering information materials is critical to increase their appropriateness and effectivness. The content should cover both the risks of injection and sharing practices and advice on how to reduce these risks and avoid sharing. But harm reduction measures should also be designed towards risk behaviour which is merely a taboo (like unprotected sex). The WHO recommends:

> To deliver information through a variety of channels, including general awareness campaigns, providing targeted information through health and social services frequented by problematic drug users and delivering information through peer and drug user networks and outreach workers. Harm reduction counselling is based on face-to-face communication and provides an opportunity for drug users to turn information into actual behaviour change through a process of clarification and reinforcement. (WHO, 2005:8)

The WHO/Europe (2005) also stresses the importance of considering the particular needs of imprisoned ethnic minorities. Western European countries are facing a high percentage of foreign prisoners in their prison systems, therefore it is necessary to first look at the language which is the most obvious barrier. Many ethnic minority prisoners would have experienced difficulties in accessing health and social care before admission and this could affect their health and addiction problems. Other models are the integration of foreign language speaking mediators and interpreters. As Europe already has a high proportion of foreign nationals in prisons, a range of measures may be necessary to facilitate information, education and communication among them.

Target group specific education is needed which is directed to the various and heterogeneous needs and resources of different prisoner groups and staff groups. This would include new strategies of transporting prevention messages (e.g. interactive ways, role plays of safer use and safer sex[2], as well as peer education initiatives for both prisoners and prison staff) (Stöver/Lines,

2 See with many practical examples: Stöver, H.; Trautmann, F. (ed., 2001): Risk Reduction For Drug Users In Prisons. Utrecht/The Netherlands (available in English, German, Russian, Estonian – Latvian and Lithuanian are under preparation).

2006). But within the prison environment it is not only the prisoners who need HIV/AIDS services, as prison staff may be placed at increased vulnerability to HIV infection because of unsafe working environments. In many cases, misinformation about routes of transmission of infectious diseases – in particular the false belief that prison staff are placed at risk of HIV infection via casual contact with HIV-positive prisoners – leads to both anxiety among prison workers and to human rights abuses of prisoners living with HIV/AIDS. Therefore educational and training programmes for staff are essential.

6.4 Adjustments in regulations and legislation

Frameworks of legislation, prison policy, and prison rules are necessary to promote effective and sustainable responses to drug addiction, infectious diseases and other damaging health challenges in prisons. Under international human rights law, states have the primary responsibility for respecting, protecting and fulfilling human rights obligations, including the right of all persons to enjoy the highest attainable standard of health. These are rights enjoyed by all persons, including persons confined in penal institutions. Therefore national governments, and international assemblies, have an obligation to ensure that rights to health care are not denied to prisoners.

International and national legislative and policy frameworks, and national and local prison policies and rules, directly affect prison management and prison regimes, and have the potential to promote or impede progress in reducing HIV transmission in prisons and caring for those living with HIV/AIDS in penal institutions. Therefore, national and international legislative and policy reform – as well as reform of prison policy and rules – should accompany the development and implementation of an effective and ethical response to health challenges in prisons, and to health care in prisons in general.

Often a reform of regional regulation, national and international legislation is necessary in order to influence the development and implementation of prison policies, prison rules, and prison programmes. Therefore the actions taken at the national level can make an important contribution to creating an environment that promotes and encourages the development of effective prison management, prison health programmes, and the ethical treatment of prisoners.

This is especially true for the continuation of treatments. The example of the introduction of substitution treatment in Polish prisons demonstrates, that the level and speed of expansion of this therapy form depends completely on the number of places available and the coverage of substitution programmes in the communities throughout the country. If places in such programmes are generally scarce and limited, it seems problematic if not unethical to provide these treatments in prisons if no continuation is foreseen after release.

6.5 Reduction of prison populations and prison reform

Overcrowded prison conditions are detrimental to efforts to improve prison living standards and prison health care services, and to preventing the spread of HIV infection among prisoners. Overcrowding presents barriers to implementing HIV/AIDS prevention and education efforts and creates conditions for increased prison violence (including sexual coercion and rape). Overcrowded living conditions also increase the likelihood that the health of prisoners living with HIV/AIDS and other health damages will suffer through exposure to other infectious diseases and to unhygienic conditions, and create additional impediments to the ability of prison medical staff to provide adequate health services.

The overuse of incarceration of drug users is of particular concern. In many countries, a significant percentage of the prison population is comprised of individuals who are convicted of offences directly related to their own drug use (i.e. those incarcerated for the possession of small amounts of drugs for personal use, those convicted of petty crimes specifically to support drug habits). The incarceration of significant numbers of drug users increases the likelihood of drug use inside prisons, and therefore an increase in unsafe injecting practices and the risk of transmission of infectious diseases. Overcrowding is likely to reduce chances for individual responses and is likely to breach confidentiality simply because an ordered approach is less possible.

Action to reduce prison populations and prison overcrowding should accompany – and be seen as an integral component of – a comprehensive strategy to prevent the transmission of infectious diseases in prisons, to improve prison health care, and to improve prison conditions. This should include the development of non-custodial strategies to reduce the over-incarceration of drug users, and to establish government targets for reducing prison overcrowding generally. Finally measures to reduce the size of the prison popu-

lation would have great benefit and achieve considerable savings (Black et al., 2004). The new *EU Action Plan on Drugs 2005–2008* (adopted by the EU commission) asks Member States to 'make effective use and develop further alternatives to prison for drug addicts who commit drug related offences' (EMCDDA, 2005).

6.6 Commitment and political and management leadership

The example of the introduction of needle exchange programmes in Spain has shown that political and management leadership already in the process of finding a consensus in this regard is necessary. Government officials, policy makers, and other relevant national and international stakeholders should take over responsibilities and develop leadership, which in a hierarchically structured and organised setting like prisons is of crucial importance. The opposite experiences have been demonstrated in Germany, which is attributed to the lack of political leadership and support in the higher ranks of the hierarchy. The newly elected Ministers of Justice in the states Hamburg and Lower-Saxony could easily abolish the needle exchange programmes more or less as a political symbol to establish the 'non-existence' of drug use in prisons. Being tough against drugs was the populistic message to be spread to the community.

The importance of political commitment and leadership has already been pointed out on international level. According to the Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS (UNGASS Declaration) 'strong leadership at all levels of society is essential for an effective response to the [HIV/AIDS] epidemic'[3]. This is particularly important among prisoners who face higher risks and lack the necessary services and support to deal with health problems.

In many countries, prison health standards and prison conditions suffer because of a lack of political and public interest in the well being of prisoners. Taking action to address the broad concerns especially raised by HCV, TB and HIV/AIDS in prisons, and enabling prison authorities to implement effective policies and strategies like harm reduction, requires the political

3 *Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS* [aka UNGASS Declaration], June 2001.

commitment to publicly identify prison health, improved prison conditions, and HCV, TB and HIV/AIDS as issues demanding government action.

Government officials, senior prison authorities, the judiciary, senior heath officials, and other informed individuals and groups, including health professional associations, civil society organisations, people living with HIV/AIDS, prisoners/former prisoners, and prison managers and prison staff, have a crucial role to play in mobilising political support for prison-based harm reduction interventions, and in supporting government actions necessary to effectively combat health damages in prisons.

6.7 Overcoming resistance from prisoners and prison staff

Resistance of staff and prisoners against harm reductions measures has been clear from the research findings, although the reasons given for both groups are quite different.

Resistance of staff against harm reduction measures is based on:

- misunderstanding about the concept and basic idea of harm reduction,
- misleading information regarding the value and impact of such measures in the context of a basic drug free orientation,
- fears of getting health injuries (e.g. needle stick injuries) and increased risks for the working place safety for prison staff.

Prisoners' resistance comes from:

- fears of getting known as an 'addict' or drug user to the prison staff and authorities (with all negative consequences such as prevented from accessing work opportunities, frequent cell searches and removal of visits and home leave) ,
- fears of getting known as an 'addict' or drug user to other prisoners (with all negative consequences e.g. bullying, being put under pressure to share the medication) ,
- fears of getting known as an 'addict' or drug user to partners and family,
- admitting to the others having sexual problems when participating in courses for 'safer sex'.

However, prisoners tended to be more familiar with a wide range of harm reduction measures in the communities, and although prisoners they do not object harm reduction measures as such, they are concerned about the negative connotations of these measures within the prison setting.

If harm reduction measures are to be introduced successfully and in a sustainable manner this resistance has to be overcome. Several strategies have been developed to address the needs of prison staff involved in the introduction of harm reduction measures. One key element of these strategies is to start from the health risks of staff to build a bridge to individual health risks for prisoners (Bögemann, 2007). The complex psychosocial problems (post-traumatic stress disorder, alcohol use, burn-out syndrome) of prison staff have to be reflected within a health promoting strategy in prisons as well.

Resistance against substitution programmes

Various factors have been identified which demonstrate the difficulties in implementing substitution programmes in prisons:

Basic drug free orientation – Substitution drugs are seen in this context also as hedonistic, psychoactive drugs (because it is also purchased on the black market from dealers who sell other illegal drugs) and not as therapeutic drugs as part of a medical treatment for drug addiction.

Lack of understanding of the nature of substitution treatment – Although many prisoners interviewed admitted relapses immediately after release, resistance against a continuity of prescription was expressed by several prisoners, who regarded their prison sentence as their only drug free time. These yo-yo effects were perceived as normal and not as explicitly health damaging.

Lack of understanding of the nature of drug use and drug dependence – Although in substitution treatment several prisoners wanted to reduce their dosage to zero shortly before release because they wanted to leave the prison 'drug free' either to avoid getting into the dependency of the methadone prescribing clinics outside again or wanting to avoid the drug scene around dispensing clinics. Unknowingly, this practice exposed them to enormous risks when relapsing. Prisoners want to hide their drug use for several reasons (one is that they fear prejudices and disadvantages for their current sentences as being viewed and treated as a 'drug user' when being in a substitution programme), which would become apparent immediately to other prisoners and staff when entering the medical units on a daily basis.

Engaging prison staff with harm reduction services – Several examples can be shown that prison staff can successfully and within a short period of time support harm reduction measures. The analysis of the introduction of harm

reduction measures like needle exchange programmes in prisons (see chapter 4.4; see also Meyenberg et al., 1999) convincingly shows that staff once educated and informed about the targets of specific programmes can be engaged in harm reduction measures.

6.8 Human rights legislation and international guidelines

As well as the structural and political barriers discussed above, the stigmatisation of prisoners has often meant that their right to health care has often been ignored (Stöver/Lines, 2006). As a result, improvements in prison harm reduction services have often come about through advocacy. Prisoners are entitled, without discrimination, to the same standard of health care that is found in the outside community, including preventive measures. This principle of equivalence is fundamental to the promotion of human rights and best health practice within prisons, and is supported by international guidelines on prison health and prisoners rights. While HIV/AIDS prevention, harm reduction and treatment programmes in prisons have indeed improved – in some cases dramatically – over the past 20 years, the vast majority of prison systems are still failing to meet this equivalency standard, which predates the HIV/AIDS epidemic by several decades. It was articulated as early as 1955 in the United Nations Standard Minimum Rules for the Treatment of Prisoners, Principle 9, which states, 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'. It has subsequently been reflected in numerous other international instruments[4], as well as in national prison policy and legislation in many countries.

4 In addition to the other United Nations instruments mentioned, see also the Basic Principles for the Treatment of Prisoners (1990), as well as the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1982), which states: Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained. Additionally, in a 1996 statement before the Commission on Human Rights (1996), UNAIDS declared, "With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community".

With HIV/AIDS, the principle of equivalence has taken on new and additional urgency, and a growing number of important international health and human rights documents have specifically applied it to HIV/AIDS (Lines/ Stöver, 2006). WHO has shown important leadership in this regard. In 1993, WHO published Guidelines on HIV infection and AIDS in prisons (1993), specifically applying the principle of equivalence to HIV/AIDS. *Principle 1* of the guidelines emphasizes, "All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination … with respect to their legal status". *Principle 2* further states that "general principles adopted by national AIDS programmes should apply equally to prisons and to the general community". The guidelines go on to detail the key elements of a comprehensive and ethical response to HIV/AIDS in prisons. Although well over 10 years old, the documents continuing relevance is perhaps the starkest illustration of the failure of prison systems across Europe to meet their international obligations regarding health. Since 1993, WHO has published a series of important documents on the issue of HIV/AIDS in prisons. They include Prison, drugs and society (2001); the Moscow Declaration (2003); a policy brief on reducing HIV transmission in prisons (2004); and most recently, a status paper on prisons, drugs and harm reduction (2005) and finally the Health in Prison Guide (2007)[5]. All have been important, both in highlighting the issue of HIV/AIDS in prisons and in providing advocates and NGOs (nongovernmental organizations) with tools to fi ght for national policy change.

Another development since the mid-1990s that has helped drive health policy change and respect for human rights is the establishment of networks of NGOs and/or prison offi cials to share and promote models of best practice, and in some cases to engage in advocacy initiatives. Perhaps the most well known and influential of these has been the WHO Health in Prisons Project (HIPP[6]), established in 1995. Annual HIPP conferences and networking meetings have highlighted numerous prison health issues, including HIV/ AIDS. Similar networks created during this time but with a specific focus on HIV/AIDS and harm reduction include the European Network on Drugs and Infections Prevention in Prison (ENDIPP[7]) and the Central and Eastern

5 http://www.euro.who.int/InformationSources/Publications/Catalogue/20070521_1 (accessed 11th July 2007)

6 www.hipp-europe.org

7 www.endipp.net (accessed 5 May 2007)

European Harm Reduction Network (CEEHRN[8]). While the latter does not focus exclusively on prisons, it does provide an important forum for NGOs working on health in prisons.

The efforts of NGOs, medical experts and people living with HIV/AIDS (PLWHA) in many countries have been critical in advancing national prison health policy. Their work includes not only lobbying governments, but also providing HIV/AIDS services directly to prisoners. Increasingly, HIV/AIDS has also been taken up as an issue by prisoners rights NGOs, who have added their voices to calls for improved HIV/AIDS programmes. International groups such as Penal Reform International and the International Centre for Prison Studies, as well as national NGOs such as the Irish Penal Reform Trust, have played important roles in promoting prisoners right to HIV/AIDS services. Perhaps the most signifi cant example of civil-sector cooperation in recent years was the 2004 Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia (Lines et al., 2004), whose call for international action on HIV/AIDS in prisons was endorsed by over 100 NGOs and experts from 25 countries.

6.9 The need for protocols, standards of care and guidelines

In many ways clear protocols and guidelines are the result of professionals dealing with health challenges as they guide successful practice and deliver a systematic response towards health threats. Examples of good practice in the development of guidelines are to be found all over the world, including the EU, as are standards of care and protocols for dealing with issues that arise.

For example, in the UK the British Medical Association (2004) presents clear guidelines for medical staff working with all detainees (including prisoners, police detainees, asylum seekers), to ensure their healthcare needs are met. These include a thorough assessment of both physical and mental health at the start of the detention period, using external services as necessary if the problems presented are beyond the scope of staff and ensuring all staff working with healthcare professionals are aware of their role and duties. Throughout the EU, prison administrations follow international standards set by the

8 http://www.ceehrn.org/ (accessed 5 May 2007)

WHO (HIPP) guidelines, and the CPT[9] regularly presents reports on a variety of detention facilities, with regards to conditions and treatment by staff.

Clear protocols and standards are necessary to ensure the human rights of prisoners are maintained and also allow for detainees to address concerns on the basis of treatment which does not adhere to such standards. The Council of Europe has developed rules for the care of prisoners in the EU, the purpose of which are to establish minimum standards for prison administrations; to serve as a 'stimulus to prisons and administrations' so they develop policies based on good practice and principles of equity; to encourage prison staff to adopt a professional attitude that reflects the 'important social and moral qualities of their work' and to provide conditions to optimise this and to provide realistic criteria for prison administrations and those responsible for inspecting prisons on which to base their judgements of performance and 'measure progress towards higher standards' (CPT, 1987).

6.10 Continuity of treatment

Prisoners should begin to be prepared for release on the day the sentence starts as part of the sentence planning process. All staff should be involved in preparing prisoners for release. Good release planning is particularly important for drug-using prisoners. The risks of relapse and overdose are extremely high. Measures taken in prison to prepare drug-using prisoners for release include:

- implementing measures to achieve and maintain drug-free status after release,
- granting home leave and conditional release, integrated into treatment processes,
- cooperating with external drug services or doctors in planning a prisoner's release,
- involving self-help groups in the release phase; and
- taking effective measures in prison to prevent prisoners from dying of a drug overdose shortly after release.

The challenge for prison services in facilitating a successful return to the community for prisoners without relapsing is not only to treat a drug prob-

9 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

lem but also to address other issues, including employability, educational deficits and maintaining family ties.

Aftercare

Several studies (Zurhold et al., 2005) show that effective aftercare for drug using prisoners is essential to maintain gains made in prison-based treatment. Nevertheless, prisoners often have difficulty in accessing assessments and payment for treatment on release under community care arrangements. The following conclusions are drawn from a multi-country survey on aftercare programmes for drug-using prisoners in several European countries (Fox, 2000):

- Aftercare for drug-using prisoners significantly decreases recidivism and relapse rates and saves lives.
- Interagency cooperation is essential for effective aftercare. Prisons, probation services, drug treatment agencies and health, employment and social welfare services must join to put the varied needs of drug-using offenders first.
- Drug treatment workers must have access to prisoners during their sentence to encourage participation in treatment and to plan release.
- Short-sentence prisoners are most poorly placed to receive aftercare and most likely to re-offend. These prisoners need to be fast-tracked into release planning and encouraged into treatment.
- Ex-offenders need choice in aftercare. One size does not fit all in drug treatment.
- Aftercare that is built into the last portion of a sentence appears to increase motivation and uptake.
- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend.

Working with families and maintaining family ties

The European Health Committee (established in 1954 by the Committee of Ministers of the Council of Europe) stated in 1995:

> "One of the inevitable consequences of imprisonment is the temporary weakening of social contacts. It is true that family ties are not broken off completely, in the sense that in most cases a visit of at least one hour per week is permitted; nevertheless the prisoners' rela-

> tionships suffer enormously from the confinement. A large number of wives, husbands and children of detainees feel punished themselves to a similar extent as their convicted spouses and fathers. Besides, and worse still, in many cases the marriage is bound to fail or be ruined."

Social contacts in general also suffer as a consequence of the imprisonment. In some countries such as Denmark and Switzerland, prisoners are given the opportunity to see their partners without supervision. Supervision is fairly relaxed in Sweden. Working with families of prisoners is a central part of rehabilitation and social reintegration in many countries. In some (such as Scotland, United Kingdom), special family contact development officers are employed to help families to keep or initiate contact with prisoners' relatives, to help to work on relatives' drug problems, to inform families about drug problems in prison and outside and to enhance family visits.

Throughcare

The drug strategy of HM Prison Service for England and Wales (United Kingdom Parliament, 1999) defines throughcare as follows: "By throughcare we mean the quality of care delivered to the offender from initial reception through to preparation for release establishing a smooth transition to community care after release". The aims are as follows:

- to understand the pressures and fears affecting people's judgement on entry to prison;
- to ease the transition process between the community and prison for drug users;
- to provide continuity, as far as possible, for those receiving treatment and support in the community on arrival in prison, on transferring between prisons and on returning to the community;
- to recognize the opportunity that imprisonment offers to drug users to begin to deal with their drug misuse problem, particularly for those with no experience of community helping agencies;
- to ensure that drug users have the opportunity of leaving prison in a better;
- physical state, with a less chaotic lifestyle, than when they entered; and
- to minimize the dangers of reduced tolerance levels on release from prison.

(United Kingdom Parliament 1999, 15)

The Scottish Prison Service has general considerations required for throughcare:

- good working relationships and clear lines of communication between prisons and external service agencies;
- drug workers using a partnership approach in prison with their clients;
- encouraging contacts between external agency and inmate; and
- maintaining continuity of care where possible, particularly for short-term prisoners.

Throughcare must involve multi-agency cooperation, which means intensive integration of external agencies that, at the time of release, will continue these efforts. The point of release is vital: how will the treatment work started in prison be continued on the outside, and have the treatment in prison and that available outside been coordinated? The phase of preparation for release should involve community based professional drug workers. After release, probation officers are involved in further treatment.

Links with NGOs and community health services

Regular contact with local community services and the involvement of voluntary agencies can assist greatly in promoting health and well-being in prisons. Where possible, prisoners should be connected to key community services before leaving prison, such as probation or parole and social and health services (see Möller et al., 2007).

Counselling and the involvement of community health structures including NGOs is a key part of connecting prison health care with public health care. Disease prevention material from the outside cannot simply be transferred to the prison setting – the relevant target groups require prison-adapted versions. This requires input from different groups based on interviews and focus-group discussions. Initial drafts and design need to be tested and approved. Both prison staff and prisoners greatly influence any prison environment. Both groups should therefore participate actively in developing and applying effective preventive measures and in disseminating relevant information.

Involvement and support from municipal health structures should have priority; non-governmental HIV and AIDS organizations have especially valuable expertise and networks that can contribute to enhancing the quality of material development and sustaining this as an ongoing activity.

Many Länder in Germany include external drug service providers in taking care of inmate drug users. Some prisons even have their own advisory

bureau on drug issues, and the social workers in some prisons take care of these problems. In contrast to internal workers, prisoners more widely accept and trust external workers because the outsiders have a duty to maintain confidentiality and have the right to refuse to give evidence. Moreover, the external workers are more experienced and know about the content of and requirements for the various support services offered. Counsellors on drug issues in prison should primarily provide information about the various support services and programmes available inside and outside prisons. In a second step, their efforts should focus on motivating prisoners to overcome their drug use. A major advantage of external drug counselling is that it links life inside and outside the prison and thus is very helpful for continuing treatment that was started in prison.

6.11 Substitution treatment in prisons

In order to meet the requirement that prisoners have access to the same treatments offered outside prison, prisoners falling into the following groups should be permitted to participate in methadone treatment in detention:

- those who had already started substitution treatment before imprisonment; and
- those who apply for participation in methadone treatment after incarceration, while in prison, and who meet the requirements for this treatment (Stöver/Weilandt, 2007).

Data from international studies show that some key elements have to be considered when starting substitution treatment (see also Kastelic, 2007):

- Continuity of care is required to maintain the benefits of methadone maintenance treatment.
- Maintenance treatment is more effective than detoxification programmes in promoting retention in drug treatment and abstinence from illicit drug use.
- information and education about the goals and treatment modalities and rules before substitution treatment is started.
- Adequate dosage (usually more than 60mg; see Stallwitz/Stöver. 2007).
- Acknowledging and integrating prisoner's experiences: Patients/prisoners involvement as valuable contributions to improve the quality of treatment and patient's satisfaction.
- Linkage with other treatments (HCV, HIV, STIs etc.).

- Reflecting and integrating womens' needs in designing and conducting substitution treatment (co-morbidity, polyvalent drug use, motherhood).

6.12 Needle exchange programmes in prisons

Despite the fact that the results of evaluations and practical experiences are encouraging, Needle exchange programmes remain a somewhat exotic preventive measure within prisons. In the prisons visited for this study, only one needle exchange has been implemented (Spain). The resistance of staff members, politicians and trade unions against needle exchange programmes and harm reduction measures in general is blocking the introduction of successful HIV/AIDS and Hepatitis preventive measures. Also prisoners expressed their resistance due to several reasons of fears regarding negative consequences of becoming known as 'addicts'. Syringe exchange schemes are still a hot political issue because they are supposed to symbolise the failure of keeping prisons 'drug free'. Needle exchange programmes are still subject to political decisions and strategies.

Successful models of a particular prison in a particular country cannot necessarily be transferred to another prison or country. The specific circumstances and needs of the prison as a consequence of a top-down process from political authorities have to be taken into account first when planning a Needle exchange programmes. Based on the above experiences, a bottom-up process, initiated by the institution, and a top-down process as a reaction of the political authorities, seems to favour successful installation and outcome of a prison-based Needle exchange programme.

One important lesson to be learned is that these measures are part of a broader health goal and should therefore be embedded in a global comprehensive prison-based drug and health promotion strategy. This process was part of the success of Needle exchange programmes. To this end, additional harm reduction measures are discussed and some are being introduced in prison health care services in some countries. Despite these advances, prison based harm reduction measures are progressing slowly compared to the speed of the spread of infectious diseases (Stöver/Nelles, 2004).

Chapter 7

Conclusions

Currently, the prison population in Europe is predominantly male (90–95%), with an increasing proportion of foreign prisoners. On the whole, prisoners are a vulnerable group coming from vulnerable areas of society, and their difficulties can be exacerbated by problematic drug use, exposure to infectious diseases, mental health issues and poor conditions within the prison. In addition their behaviour in prison can be high risk, such as injecting and other forms of drug use, unprotected sexual contacts and tattooing/piercing which remain associated with the transmission of infectious diseases. Health problems are over-represented in all prison systems visited compared to the outside world, and these include drug use, infectious diseases (HCV, HIV/AIDS, hepatitis, STIs and TB), suicide and self harm. The treatment of chronic conditions such as diabetes or hepatitis in prisons is also problematic due security constraints and lack of resources.

Drug strategies in prisons require actions to be taken both on the level of individual behavioural change and on the structural level. Although targeting programmes at individual prisoners or groups of prisoners is important, there is also a need for more structurally oriented measures to run concurrently, to comprehensively address necessary improvements in the living conditions of the prisoners and the working conditions of prison staff. For example, overcrowding in prisons for instance leads to lack of privacy, stress and other health problems. This comprehensive approach is targeting on evidence-based drug services on the one hand and on policy formulation and implementation on the other hand.

Throughout the EU, the introduction of harm reduction measures in prisons is still falling compared to developments achieved in the last 20 years in the community and in prison systems in other countries such as Australia and Canada (with the exception of Spain). In nearly all the prisons visited there was limited access to harm reduction measures like condoms, syringes or

bleach, therefore prisoners are not granted equality of care, as in most countries, such services are available in the community (Trimbos Instituut, 2007). An EU report emphasises this lack of equivalence, in that harm reduction interventions in prisons within the EU are still not in accordance with the principle of equivalence adopted by UN General Assembly 1, UNAIDS/ WHO2 and UNODC3, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adopt prison-based harm reduction activities to meet the needs of drug users and to improve access to services which do already exist. The need for continuity of care is particularly important for those receiving substitution treatment for drug use prior to their sentence, so they can continue with this treatment during their sentence. Also, this principle must be considered for those receiving any sort of medical treatment or other form of support such as counselling for those prisoners close to being released, to they continue to get this support in the community.

In all of the prisons visited respondents were aware of the over-representation of health risks of prisoners, however, the strategies to respond to these challenges differed in goals and methods. The findings demonstrate that the some countries' policies focus on supply reduction and HIV/AIDS-testing policies (e.g. Lithuania), while others invest in demand reduction approaches (e.g. Austria, Italy, Romania), whilst others, in addition to this adopt the more controversial approach of including harm reduction measures (e.g. Spain). However, the degree of success and effectiveness in implementing harm reduction varies widely, as in most countries, problems and difficulties were identified with the distribution of condoms, bleach, clean needles. Peer group support and education however did seem to be a more successful measure, for example as found in Romania and Spain, where prisoners were much more involved in their treatment and in supporting each other.

Apart from harm reduction strategies that seem politically difficult to implement (e.g. needle exchange projects) all prisons visited showed awareness and developed actions to reduce health risks for prisoners. The actions presented in this chapter indicate that several harm reduction measures can be

1 http://www.pogar.org/publications/garesolutions/a45-111-90e.pdf
2 http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf
3 http://data.unaids.org/pub/Report/2006/20060701_hiv-aids_prisons_en.pdf.

implemented when these strategies are supported by political leadership (with legislative or regulative changes as supposition for the introduction of HR measures), and professional consensus based on an exchange of prison health care services and those in the community.

In some of the healthcare policies of the prisons visited, the 'principle of equivalence' is referred to, which is an important achievement however it was not widely viewed as relevant or as a priority among some prison staff. It is necessary to ask whether the concept of equivalent standards of health care is still sufficient and instead promote standards that achieve equivalent objectives:

> In some circumstances, meeting this new standard will require that the scope and accessibility of prison health services are higher than that outside of prisons. (Lines 2006:269)

In all of the prisons visited health problems deriving mostly from injecting drug use afford extra efforts in policy and practice to tackle this severe problem in prison. This needs to be done in order to protect prisoners, staff, but also families and partners of prisoners in the community.

What is needed to implement harm reduction measures?

The results of our study are clearly in line with other research projects throughout the world. The evidence base for implementing harm reduction measures is relatively clear: The National Academy of Science's Institute of Medicine (IOM) (2006)[4] evaluated potential HIV prevention measures in "high risk" countries in Asia and the former Soviet Union where injecting drug use accounts for a significant percentage of HIV cases. IOM came to the conclusion that access to sterile injecting equipment reduces needle sharing and other risky behavior, and that substitution treatment with methadone or buprenorphine reduces an individual's risk of HIV. These results of an exhaustive literature review and testimony by experts from over 13 countries also highlights the chilling effect of repressive drug laws on HIV prevention efforts across the globe.

Taking action to address harm reduction services in prisons is not only controversial, but also harm reduction measures are neglected. There is limited discussion about sexual violence and rape in prison; there are no referral

4 The leading U.S. provider of authoritative information on health and science policy.

systems in place if rape among prisoners occurs and no post exposure prophylaxis and active hepatitis B vaccination for prisoners is in place, if sexual violence occurs.

Political leaders and the general public are often reluctant to support the implementation of measures proven effective in reducing the spread of infectious diseases and other health damages in prisons. This reluctance stems from societal stigma against prisoners, as well as an unwillingness to officially admit the presence of high risk behaviours such as unprotected sex and drug use in prisons. Political leadership, and the willingness to publicly identify and justify the need for comprehensive action on harm reduction measures in prisons, is therefore a key element of an effective response.

As shown in several prison systems establishing effective working links between prison-based services and community services and NGOs is essential in implementing comprehensive harm reduction strategies in prisons. As a matter of fact, prison employees can not have the same level of trust and credibility in issues like sexual contacts, tattoos, piercing, drug use.

Collaboration with NGOs can improve the standards of care in prisons, support prison staff, ensure that prison services reflect current national best practice, ensure the sustainability of prison programmes, and improve post-release follow-up for prisoners upon release. However, in most countries there is no systematic protocol to establish cooperation between NGOs and prisons. Access depends on the good will of single persons responsible within the prison system, which is a frustrating approach for NGOs and impedes the expertise and services they can offer. Therefore, there needs to be standards in place to ensure NGOs are included in addressing the needs of prisoners, particularly to improve continuity of care during the sentence and aftercare support when the prisoner is released. This continuity is lacking in many prisons visited and often results into treatment interruptions for problematic drug users and also those with infectious diseases such as HIV or hepatitis.

Learning from existing experience in developing harm reduction programmes in prisons, and using that knowledge to develop effective measures is an important strategy for prison administrations to adopt. The clear evidence demonstrating the need and effectives of harm reduction measures and how to overcome resistance to them presents useful guidelines and good practice example to ensure, as far as possible, as successful implementation. Infectious disease prevention programmes targeted at injecting drug users in

the community, for example, can be a valuable guide in the development of effective initiatives in prisons. Prison-based infectious diseases programmes internationally can provide valuable evaluated models of good and safe practice.

National and international networking and exchange of good practice models seems to be a valuable method for all prison systems to engage in. In addition, international networks and journals need to disseminate internationally available good practice models and knowledge about evidence-based strategies into the prison settings and/or on the level of prison administration. Guidelines and detailed protocols are needed on how exactly certain harm reduction policies can and have to be implemented to support prison doctors/ nurses and prison administration in delivering adequate health care services (e.g. for substitution treatment to opiate addicted prisoners).

Time limited pilot tests may be utilised as a tool in developing and implementing new or innovative programmes. Pilot test projects may be valuable in developing staff and prisoner education, prevention of infectious diseases, drug treatment services, and medical services. In addition to providing an opportunity to test project implementation processes and evaluate programme outcomes, pilot projects may be used to encourage change in staff culture, and promote wider support for the implementation of HIV programmes and services. It is essential however that pilot tests do not delay action on harm reduction in prisons, nor be used as an end in themselves. Pilot tests should always be designed as a stepping-stone to wider implementation of programmes, rather than a reason to delay or prevent wider implementation, and should be mainstreamed rapidly upon completion. This should include the development of "pilot regions" in which wider integrated responses within prisons, and between the prison and the community, are established and evaluated.

Adequate funding is key to implementing effective action, and national governments and the international donors should address issues of HIV in prisons as a primary concern in developing national harm reduction and public health strategies. At a national level, parameters of any funding allocated to national drug strategies (including harm reduction strategies), national HIV treatment roll-outs, public health programmes, women's health, youth health, and public medical care should be expanded to incorporate prisons. Similarly, the parameters of national funding to prisons and drug law enforcement should also be expanded to include harm reduction initiatives. In

assessing the issue of prisons, national governments should consider the overall cost savings of taking action to prevent the spread of infectious diseases among prisoners and the broader community and the costs of other health damages.

The coercive, punitive ethos and abstinence-based policies (excluding substitution programmes) that currently underpins prison health policy in most countries must be removed. To view the prisoner as a patient seems to be the necessary shift to achieve this, for example for those prisoners with drug dependence, to see it as a disease rather than a criminal activity, subculture and hedonistic pleasure seeking behaviour. Without this major shift, the principle of equivalence will remain only an aspiration. An important step towards this is for public health care institutions to take over the responsibility for providing health care in prisons, as is done in Norway, France and now in England & Wales.

Hard questions need to be asked about who is being sent to prison, and in particular whether incarceration is a sensible or rational response to illegal drug use. If we aspire to reduce the health risks associated with drug use in prisons, governments need to reconsider the appropriateness of prison for drug users:

> It may be that we shall eventually conclude that prison is not appropriate for those convicted of offences associated with drug use; and that for those imprisoned for different offences but who also use drugs, harm reduction represents the only solution which has any long-term future. (Shewan et al., 2000:xiii)

Alternatives to custodial sentences for problematic drug users, especially those with additional health problems and more vulnerable groups such as foreign prisoners and juveniles, can be presented as a preventative/harm reduction strategy at the policy level.

Finally, governments must acknowledge the fact that respecting the rights of those at risk is good public health policy and good human rights practice.[5]

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5 *Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS* ["UNGASS Declaration"], June 2001 states "Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response." Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System (Approved on behalf of ACC by the High-Level Committee on programme at its first regu-

Therefore, human rights must be promoted as the foundation of an effective and ethical response to health problems in prisons (Stöver/Lines, 2006; UNODC, 2006). As increasing evidence demonstrates the detrimental impact of poor prison healthcare policy and practice on public health, this becomes a concern beyond that of prison administrations and criminal justice staff and must be embraced by those responsible for wider social and healthcare policy.

lar session of 2001, Vienna, 26–27 February, 2001), paragraph 25, states "Protection of human rights is critical to the success of prevention on HIV/AIDS. People are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Where civil rights are not respected, it is difficult to respond effectively to the epidemic".

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Appendix 1:
Ethical and methodological guidelines

Harm Reduction in European Prisons – A Compilation of Models of Best Practice

Ethical and Methodological Guidelines for researching in secure settings

Introduction

The European Network for Drugs and Infections Prevention in Prison (ENDIPP) *Harm Reduction in European Prisons – A compilation of Models of Best Practice* research is using a qualitative methodology that requires interviews and focus groups with prison staff and (former) drug using prisoners. Prisoners will be asked about their drug using careers both in the community and possibly during their imprisonment. The sensitive nature of the research requires clear ethical and confidentiality procedures and guarantees for the participants. The interpreter (where necessary) who accompanies the researcher should be independent and not employed by the National Prison/Institution Administration.

In order to guarantee offender and staff confidentiality it is important that the following is agreed with both the Director General of the National Prison/Institution Administration and the individual prison/institution directors where the research will take place in each of the countries participating in the research.

Aims and objectives

Key aim: To provide an overview of the legislation, policy and practice concerning harm reduction services provided for problematic drug users (PDUs) in 9 European Union (EU) countries.[1]

1 Fieldwork visits to be completed in 8 countries, with data collection by post for the remaining 1.

Objectives:
- To analyse international, national policies on harm reduction (literature review).
- To undertake a review of the national strategies of harm reduction for problematic drug users both in the community and in prisons in 9 European countries.
- To explore how harm reduction is conceptualised in different cultural contexts.
- To identify existing harm reduction initiatives in prisons, which will be analysed on several levels: development, introduction, implementation, evaluation, and at the system-level.
- To identify the obstacles and barriers that need to be to overcome in order to implement harm reduction measures in prisons.
- To examine in detail the policies and harm reduction services in place in two sample institutions which address the needs of problematic drug users.
- To investigate the implementation process of harm reduction services currently offered to problematic drug users in the two sample institutions.
- To study perceptions of these harm reduction measures with all involved stakeholders (prison management, staff, prisoners).
- To identify models of best practice.
- To promote awareness of the harm reduction initiatives operating in the area of problematic drug users in custody.
- To present examples of harm reduction measures in prisons from each of the sample countries.

Participants and data collection

In order to achieve the aims of the research we would like to interview:

At the National Prison Administration:
- the Director General of the national prison administration;
- the person responsible for the drug strategy;
- the person responsible for the harm reduction strategy;
- the person responsible for treatment (problematic drug use);
- the person responsible for health care;
- Other key people as advised.

In the sample prisons/institutions:
- the prison/institution director;
- the person responsible for security;
- the person responsible for harm reduction;
- the person responsible for treatment (problematic drug use);
- the person responsible for health care;
- the person responsible for through care liaison with the community;
- specialist staff (psychologist, psychiatrist, social worker, educator, resettlement workers etc);
- NGO staff working in partnership within the institution;
- Other key people as advised.
- Focus group of drug users in custody.

In addition, in order to collect comparable statistical data from each of the sample countries it would be helpful if the data detailed in the attached sheet could be provided (Appendix 1) at the time of the visit to the central prison administration.

The researcher would like to visit *two prisons* in order to interview the key staff (detailed above) and hold a focus group of drug users in custody, for each institution. It is anticipated that *two days* will be required in each institution in order to complete the focus groups and interviews and *one day* to interview the key staff at the National Prison Administration.

The following information is provided to ensure that ethical and confidentiality guidelines are adhered to during the course of the research.

1. Drug users in custody focus groups

1. There should be no more than 10 (former) drug users in a focus group;
2. The focus group will last no longer than one and a half hours;
3. The researcher and interpreter should be allowed to run the focus group without the presence of any prison staff (this is important to allow prisoners to speak freely about issues of drug use);
4. The focus group should take place in a room where the discussion can not be overheard and thus ensure confidentiality;
5. That it is made clear to the prisoners what the subject to be discussed during the focus group is and that they are asked if they wish to

participate and that they are told that they are free to leave at any point during the focus groups;

6. That they are told that anything they say during the focus group will be confidential and that they will not be named in the end report of the research;

2. In-depth Interviews with prison staff

1. The interviews should take no longer than 45 minutes with each participant;
2. The researcher and interpreter should be allowed to interview respondents individually; (There may be occasions when it is appropriate to talk to a group of staff working in a particular department in the prison and this can be negotiated in each prison in the sample);
3. The interviews should take place in a room where the discussion can not be overheard and thus ensure confidentiality; (It is often helpful if the interviews can take place in the area of the prison where the respondent works both for the quality of the discussion and to avoid staff waiting around for a previous interview to finish)
4. That staff are told that anything they say during the interview will be confidential and that they will not be named in the end report of the research;
5. That all respondents are asked if they wish to participate in the research and that they are free to discontinue the interview if they so wish.

Country where research is taking place: ……..

Signed agreement that the research may take place based on the above information about the research methodology and ethical guidelines:

Name of Director General (or appropriate other):

Signature: …….

Date: ……

Statistical Data for whole prison system and juvenile offender institutions for (Country)*

Please provide the following information for *December 2004* to *December 2005*

NUMBER OF ESTABLISHMENTS/INSTITUTIONS	
Adult prisoners: Pre-trial sentenced Male Female	Juveniles in custody: Pre-trial Sentenced Male Female
DEFINITION OF JUVENILES (MINORS, YOUNG PRISONERS)	
Total prison population (including pre-trial detainees / remand prisoners)	
Prison population rate (per 100,000 of national population)	
Number of Pre-trial detainees/remand prisoners within the total prison population	
Official Capacity of prison system	
Number of Juveniles in custody within the total prison population	
Number of known problematic drug users % of prison population	
PREVALENCE OF COMMUNICABLE DISEASES (i.e. Number of males and females and total as % of prison population for each below):	
Hepatitis A: Male: Female: %:	TB: Male: Female: %:
Hepatitis B: Male: Female: %:	Syphilis: Male: Female: %:
HIV/AIDS: Male: Female: %:	Hepatitis C: Male: Female: %:
Number of suicides	
How is self harm defined?	
Incidences of Self Harm	
Are any NGOs working in partnership with the prison system that provide services (harm reduction, needle exchange, counselling etc) for problematic drug or alcohol users?	

* Based on Roy Walmsley, World Prison Brief

Appendix 2: Interview checklists

Harm Reduction in European Prisons – A Compilation of Models of Best Practice

Interview questions for National Prison Administration

General information

1. What is the current population of prisoners nationally? Are your prisons overcrowded?
2. Is overcrowding an issue for the prison system? How does this affect the regime (i.e. ability to work, access to training programmes, education?)
3. Has the current population of problematic drug users in prison risen since last year? Is this a concern (reasons)? Percentage of prison population? Is this the same for male and female prisoners and juveniles?
4. What is the current population of foreign/minority ethnic prisoners in this institution? What services do you provide to assist them? Do you have translators?
5. Are you concerned about bullying in your prisons? Strategy in place to prevent bullying and details.
6. Are you concerned about self harming or suicide in your prisons?
7. Is sex in prisons considered to be a problem? How is it controlled/dealt with?
8. Is healthcare provision considered to be equivalent to community provisions?
9. What provision is made for staff welfare?

Problematic drug users

Drug use

10. What do you consider to be the main problems regarding problematic drug users in custody?
11. How are services for PDUs affected by the regime and security considerations of the prison service?

12. Do you consider the (current) use of drugs among prisoners to be a problem? Strategies in place?
13. Is there a national prison strategy for problematic drug users? Who are the key staff involved in implementing this strategy? Do individual prisons have their own strategy (i.e. tailored to the actual problems faced in their prison i.e. pre-sentence, sentenced or juvenile prisoners)?
14. What training is in place for staff in dealing with problematic drug users in prisons?
15. What education or training is in place for problematic drug users in prisons?

Health care

16. What are the associated health care problems of PDUs? (HIV/AIDS, Hepatitis, STIs?)
17. What are the key healthcare provisions for PDUs in custody?
18. Does the national strategy for healthcare and or drugs for PDUs in custody include any harm reduction measures?

Harm Reduction Services

19. To what extent is harm reduction addressed in the national prison strategy? What are the key components mentioned? Who is responsible for implementing harm reduction?
20. What are the main issues for the national prison administration regarding harm reduction in prisons?
21. What is the national prison administration's view about provision of harm reduction tools – i) distribution of condoms ii) substitution treatment iii) needle exchange iv) bleach vi) group work (counselling) vii) peer group viii) information provision?
22. Which of these have been implemented in the prison system? Are they available in all prisons? Available for juvenile, male and female prisoners? Do prisoners on remand (pre-trial) have access to them? (if none go to question 27)
23. What were/are the key problems in implementing **X** harm reduction measures i) politically ii) in the individual prisons? How were these overcome? (staff training, use of peer educators, direct orders etc).
24. How was the process of implementation and perception/acceptance by staff (trade unions) and prisoners?

25. Did the impetus for the introduction of these measures come from the top down or from staff working with PDUs (i.e. bottom up) or via NGO intervention?
26. How were a) staff and b) prisoners prepared for the introduction of harm reduction measures?
27. Does the prison service work with voluntary or non-government organisations in providing harm reduction services for problematic drug users? How are they received in the individual prisons by staff and by prisoners?
28. Is there an intention in the future to implement any (other) harm reduction measures?
29. Is there a contradiction between the implementation of harm reduction measures and the provision of drug free units?

Interview questions for each sample institution

A. Sample Prison/Institution: Director/Governor

General Information

1. Do you hold male/female offenders or both?
2. What is the current population of prisoners in your institution?
3. Are you concerned about overcrowding in this institution? How does this affect the regime of the institution? Are all prisoners able to work?
4. Is the number of PDUs rising? Is this a concern? Percentage of prison population?
5. What is the current population of foreign/minority ethnic prisoners in this institution? What services do you provide to assist them? Do you have translators?
6. What is the average number of prisoners in cells? How much time do they spend in them? What other space is available for them?
7. How is bullying dealt with in this institution? Details of strategy to prevent bullying.
8. Are you concerned about self harming and suicide among prisoners in custody? What is the response to self harming?
9. Is sex in this institution considered to be a problem? How is it controlled/dealt with?
10. How is this institution's health care provision structured? Is it equivalent to health care provision in the community?
11. What provision is made for staff welfare?

Problematic drug users

Drug use

12. What are your views generally on the management of PDUs in custody?
13. Do you consider the (current) use of drugs among prisoners to be a problem in this prison? Strategies in place?
14. What is the strategy for PDUs in custody during their first few days in this institution?

15. What are the key services you provide for problematic drug users?
16. Is there a national prison drug strategy? Do you have a specific drug strategy for this prison? What does it contain?
17. Who are the key staff involved in implementing this strategy?
18. What training is in place for staff dealing with problematic drug users? Who provides this training? Have all staff received this? Who delivers this training? How often is it updated?
19. What education or training is in place for problematic drug users in this prison?
20. What services are provided for PDUs on entering this institution? How are these services maintained? Who delivers them? Have drug free units been established?
21. How are services for PDUs affected by the regime and security considerations of this institution?

Health care

22. What are the associated health care problems of PDUs? (HIV/AIDS, Hepatitis, STIs?)
23. What are the key healthcare provisions for PDUs in this prison?
24. Does the national strategy for healthcare and or drugs for PDUs in custody include any harm reduction measures?

Harm reduction

25. Does the prison have a harm reduction strategy? What are the key components?
26. What harm reduction measures are in place in this prison?
27. Who is responsible for implementing harm reduction in the prison?
28. What is your view about provision of harm reduction tools i) distribution of condoms ii) substitution treatment iii) needle exchange iv) bleach vi) group work (counselling) vii) peer group viii) information provision?

Can you tell me more about the introduction and implementation of …… X measures

29. What are/were the key problems in implementing X harm reduction measures
30. politically

31. in the individual prisons? How were these overcome? (staff training, use of peer educators, direct orders etc)?
32. How was the process of implementation and perception/acceptance by staff (trade unions) and prisoners?
33. Did the impetus for the introduction of these measures come from the top down or from staff working with PDUs (i.e. bottom up) or via NGO intervention?
34. How were a) staff and b) prisoners prepared for the introduction of harm reduction measures?
35. Do you work in partnership with voluntary or non-government organisations in providing harm reduction services for PDUs? How are/were they received by prison staff and by prisoners?
36. Is there an intention in the future to implement any (other) harm reduction measures?
37. Is there a contradiction between the implementation of harm reduction measures and the provision of drug free units?
38. What would help you to do your job better?

If no measures currently implemented:

39. Is there an intention in the future to implement any harm reduction measures?
40. What do you think the key problems in implementing X and Y would be? How will you overcome this?
41. What would help you to do your job better?

B. Sample Prison/Institution: Security staff

General Information

1. Is there an induction programme for new prisoners? What does it contain? Are you involved? Is there a special programme, unit, strategy for PDUs?
2. Do you get to know the prisoners and PDUs well? Are there good relationships between security staff and prisoners?
3. Do you have a counselling role with PDUs?
4. Are there good facilities available to PDUs? What are they?
5. What, in your view, are the most common complaints raised by PDUs?

6. Do you consider bullying to be a problem? Is there a strategy to deal with this?
7. Is there a high amount of self-harming or suicide attempts within this institution? What is the response to self harming?
8. Is sex in this institution considered to be a problem?

Drug use in this institution

9. Is there a problem with drug use within this institution? Are there drugs available within the prison?
10. What are the rates of confiscation of drugs and/or syringes and needles?
11. What is the security response to problematic drug use? How does this fit in with the institution's strategy? How are you involved in this? Do you think that you should have more input?
12. Are there drug treatment/programmes within this institution? Does security have a role (e.g. cooperation/information) with them?
13. Can you identify any problems with implementing treatment programmes for PDUs?
14. What strategies are in place to prevent the supply of drugs into this institution? Sniffer dogs? (Body)Searches of visitors and offenders?
15. What do you feel about harm reduction in terms of providing such things as clean needles, drug-free wings, substitution treatment and condoms for PDUs? Were you involved in implementing these?

Staff welfare and training

16. What facilities are provided for security staff e.g. medical care, counselling support, housing, recreation etc?
17. What opportunities do you have for professional development (training courses etc)? What would you like?
18. Is harm reduction training available for staff? Do you think it would be useful?
19. Would you find it useful to have training on the risks associated with problematic drug use, e.g. the spread of communicable diseases?
20. What would help you to do your job better?

C. Sample Prison/Institution: Healthcare staff

General information

1. What is the initial health screening procedure for prisoners? Are they fully aware of all tests taken? Is their confidentiality ensured? How?
2. Are you involved in the induction programme for prisoners?
3. Are you concerned about overcrowding in this institution? How does this affect the provision of health care?
4. Do you get to know the prisoners well? Are there good relationships between health care staff and prisoners?
5. Do you have good relationships with outside agencies (to allow for effective through care)? Examples?
6. Are there good healthcare facilities equivalent to those in the community available to prisoners? What are they?
7. How closely do health professionals work with outside medical services and hospitals? Are there good relations/links with the community health services?
8. How long does a prisoner have to wait to see a doctor?
9. Are there any problems you are aware of for prisoners accessing healthcare in this institution? Are there adequate medicines and medical equipment provided?
10. What arrangements do you have in place for psychiatric care?
11. What are the showering facilities like and how often can prisoners use them? Is this always with hot water?
12. Do staff offer healthcare and hygiene advice to prisoners? What about nutrition, dental health, eye tests etc? Do cells have sanitation facilities within them?
13. Do you consider bullying to be a problem? Is there a strategy to deal with this?
14. Is sex in this institution considered to be a problem? How is it controlled/dealt with?
15. Is there a high amount of self-harming or suicide attempts within the prison? What is the response to self harming?

Role of Health care and PDUs

16. Is the number of PDUs rising in this prison? Is this a concern?
17. Do you think there is a problem with drug use in this institution?

18. Is there a drug strategy/action plan for this institution? Are you involved with its development and implementation? Are there now programmes for PDUS? What services do they provide? Have drug free units been established?
19. What are the associated health care problems of PDUs? (HIV/AIDS, Hepatitis, STIs?)
20. Do you have a role in provision of treatment and services for PDUs (counselling etc)?
21. What training is in place for staff dealing with problematic drug users (i.e. substance misuse)? Have all staff received this? Who delivers this training? How often is it updated?
22. Are your treatment programmes monitored and evaluated?
23. Do you have links with voluntary and non government organisations?
24. Do you think that there is good liaison between the various professional groups working with problematic drug use within this institution and also outside it?

Harm Reduction

25. Is there a centrally designed harm reduction strategy for this institution? What does it consist of? Prevention of infectious diseases (dealing with blood spills, communicable diseases e.g. HIV/AIDS, TB, Hepatitis, etc)?
26. Have all health care staff had pre and post test counselling (e.g. HIV) training? Who delivered this?
27. Who delivers the information for harm reduction? Do healthcare staff and/or prisoners have a role in this? Do all PDUs receive this? At what stage? Individually or in groups?
28. Do all health care staff have harm reduction training?
29. What is your view about provision of harm reduction tools i) distribution of condoms ii) substitution treatment iii) needle exchange iv) bleach vi) group work (counselling) vii) peer group viii) information provision?
30. What harm reduction measures are in place in this prison? Are these available in other languages? Are there more pro-active or interactive strategies being operated? Do you see these strategies as being integrated into the institution regime?

Can you tell me more about the introduction and implementation of…… X measures

31. What are/were the key problems in implementing X harm reduction measures
    i) politically
    ii) in the individual prisons? How were these overcome? (staff training, use of peer educators, direct orders etc)?
32. How was the process of implementation and perception/acceptance by staff (trade unions) and prisoners?
33. Did the impetus for the introduction of these measures come from the top down or from staff working with PDUs (i.e. bottom up) or via NGO intervention?
34. How were a) staff and b) prisoners prepared for the introduction of harm reduction measures?
35. Do you work in partnership with voluntary or non-government organisations in providing harm reduction services for PDUs? How are/were they received by prison staff and by prisoners?
36. Is there an intention in the future to implement any (other) harm reduction measures?
37. Is there a contradiction between the implementation of harm reduction measures and the provision of drug free units?
38. What would help you to do your job better?

If no measures currently implemented:

39. Is there an intention in the future to implement any harm reduction measures?
40. What do you think the key problems in implementing X and Y would be? How will you overcome this?
41. What would help you to do your job better?

D. Sample Prison/Institution: Psychologists, educators, social workers, pedagogues, resettlement workers

General information

1. Is there an induction programme for new prisoners? What does it contain? Are you involved?
2. How many prisoners (and PDUs?) are you responsible for at any one time?
3. Do you get to know the prisoners well? Are there good relationships between specialist staff and prisoners?
4. Do you have good relationships with outside agencies (to allow for effective through care, e.g. substitution treatment)?
5. Are there good facilities available to prisoners? What are they?
6. What, in your view, are the most common complaints raised by prisoners?
7. Is sex considered to be a problem in this institution?
8. Do you consider bullying to be a problem? Is there a strategy to deal with this?
9. Is there a high amount of self-harming or suicide attempts within the prison? What is the response to self harming?

Provisions for PDUs

10. Is the number of PDUs rising in this prison? Is this a concern?
11. Do you think there is a problem with drug use in this institution?
12. Is there a drug strategy/action plan for this institution? Are you involved with its development and implementation? Are there now programmes for PDUS? What services do they provide? Have drug free units been established?
13. Do you have a role in provision of treatment and services for PDUs (counselling etc)?
14. What training is in place for staff dealing with problematic drug users (i.e. substance misuse)? Have all staff received this? Who delivers this training? How often is it updated?
15. Are your treatment programmes monitored and evaluated?
16. Do you have links with voluntary and non government organisations?

17. Do you think that there is good liaison between the various professional groups working with problematic drug use within this institution and also outside it?

Harm reduction

18. What is your view about provision of harm reduction tools i) distribution of condoms ii) substitution treatment iii) needle exchange iv) bleach vi) group work (counselling) vii) peer group viii) information provision?
19. What harm reduction measures are in place in this prison? Are these available in other languages? Are there more pro-active or interactive strategies being operated? Do you see these strategies as being integrated into the institution regime?
20. Do you think harm reduction measures for PDUs in prison contribute to successful re-integration into community?

Can you tell me more about the introduction and implementation of …… X measures

21. What are/were the key problems in implementing X harm reduction measures
    i) politically
    ii) in the individual prisons? How were these overcome? (staff training, use of peer educators, direct orders etc)?
22. How was the process of implementation and perception/acceptance by staff (trade unions) and prisoners?
23. Did the impetus for the introduction of these measures come from the top down or from staff working with PDUs (i.e. bottom up) or via NGO intervention?
24. How were a) staff and b) prisoners prepared for the introduction of harm reduction measures?
25. Do you work in partnership with voluntary or non-government organisations in providing harm reduction services for PDUs? How are/were they received by prison staff and by prisoners?
26. Is there an intention in the future to implement any (other) harm reduction measures?
27. Is there a contradiction between the implementation of harm reduction measures and the provision of drug free units?

28. What would help you to do your job better?

If no measures currently implemented:

29. Is there an intention in the future to implement any harm reduction measures?
30. What do you think the key problems in implementing X and Y would be? How will you overcome this?
31. What would help you to do your job better?

E. Sample Prison/Institution: NGOs, volunteers

General information

1. What is your role within this institution?
2. How long have you/your organisation been coming to this institution?
3. Do you have good access to PDUs?
4. Are you involved in through care (e.g. continuing treatment initiated in prison)?
5. What are the key problems that PDUs identify to you?
6. What is the feeling about PDUs in the local community?
7. Do you provide any services/help for foreign prisoners?
8. Is sex considered to be a problem in this institution?

Provisions for PDUs

9. Do you think there is a problem with drug use in this institution?
10. How involved are you with the drug strategy/action plan for this institution? How does it fit with the community drug strategy and provision in the community?
11. What services do you provide for PDUS?
12. Are your programmes monitored and evaluated?
13. Do you think that there is good liaison between the various professional groups working with problematic drug use within this institution?

Harm reduction

14. What harm reduction measures are in place in this prison? Are these available in other languages? Are there more pro-active or interactive strategies being operated? Do you see these strategies as being integrated into the institution regime?
15. Do you think harm reduction measures for PDUs in prison contribute to successful re-integration into community?

Can you tell me more about the introduction and implementation of…… X measures

16. What are/were the key problems in implementing X harm reduction measures
    i) politically
    ii) in the individual prisons? How were these overcome? (staff training, use of peer educators, direct orders etc)?
17. How was the process of implementation and perception/acceptance by staff (trade unions) and prisoners?
18. Did the impetus for the introduction of these measures come from the top down or from staff working with PDUs (i.e. bottom up) or via NGO intervention?
19. How were a) staff and b) prisoners prepared for the introduction of harm reduction measures?
20. Is there an intention in the future to implement any (other) harm reduction measures?
21. Is there a contradiction between the implementation of harm reduction measures and the provision of drug free units?
22. How could your role be made easier/improved?

F. Sample Prison/Institution: PDUs – focus group discussion (to last for up to 90 minutes)

General facilities

1. Do you feel that you have enough room/space in your cell? Number of people in your cell?
2. Is there hot water available in your cell?
3. What are the toilet facilities like (separated by curtain/wall)? Availability of basic hygienic equipment (toothpaste/brush; soap, toilet paper)?
4. How often do you have access to showers?
5. What access do you have for physical exercise? Daily exercise for 1 hour? Access to the gym? Availability of suitable clothing for using sports facilities? How often?
6. What access to education do you have?
7. Access to medical care? How is it achieved via educator/nurse/other? How long do you wait to see the doctor?
8. Access to specialist care? Psychologists etc?

Drug use, drug treatment and other issues

9. Is there a lot of drug use in this institution - medicines or other? What sort of drugs do you think people use? Are prisoners injecting, smoking, both or other?
10. What are the main dangers for these drug users?
11. Are you currently receiving drug treatment programme/therapy?
12. Are there any peer group programmes? Are/were you involved? Do you think this is/would be helpful?
13. Has being in prison (and the treatment you have received) helped you to change your drug using behaviour?
14. Did you need/receive detoxification at entry to this institution?
15. Were you having drug therapy/treatment or any other health care in the community? Were you able to continue this treatment while you have been in prison?

Harm reduction

16. What harm reduction materials have you seen while in this institution? What would you find useful? Drug awareness, safer sex etc? What is missing?
17. Have you received information about HIV and other infectious diseases? In small groups? Who provides this? Did you find it informative?
18. Is there sexual activity going on in this prison?
19. Do you think that it would be useful to have condoms available in this institution?
20. Do you think that it would be useful to have clean needles and syringes available in this institution?
21. Do you think that it would be useful to have substitution maintenance treatment available in this institution?
22. Is self-harming a problem? What is the response to self-harming? Who would you go to for help/advice?
23. If you had a wish list what two things would you most like to see changed in this institution?

Problematic drug users and harm reduction - focus group sheet

What help is available for those with a drug problem in this institution/prison? Have you found it helpful? Who in this institution /prison would you go to talk about drug problems?	Do you think that drugs are being used in this institution/prison? What kind of drugs are available?
Are you aware of risk behaviour? Have you been given any information on this (e.g. courses on safer drug use, safer sex etc)? Do you think that harm reduction measures (e.g. condoms, needle exchange, substitution treatment) should be available here?	What two things would you like to change in the institution/prison? Please add anything else that you think is important.