



UNITED NATIONS  
*Office on Drugs and Crime*

**Treatnet**  
International network of drug dependence  
treatment and rehabilitation resource centres

# Drug Dependence Treatment: Interventions for Drug Users in Prison



Forward

## Disclaimer

This document has been prepared by a professionally and geographically diverse working group with participants from five drug dependence treatment centres as part of UNODC project GLO/H43 "Treatnet – International Network of Drug Dependence Treatment and Rehabilitation Resource Centres".

The views expressed are solely those of the authors and do not necessarily reflect the policies or views of UNODC. A reference to a document or website does not imply endorsement by UNODC of the accuracy of the information contained therein.

Please note that this version of the good practice document will be further developed and adapted to be used as training tools.

## Acknowledgements

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During Phase I this project developed an international network of drug treatment and rehabilitation resource centres in all regions, with a view to facilitating dissemination of knowledge and good practices. This document has been produced by members of one of four working group consisting of representatives from Treatnet members, and the topics include: community-based treatment, the Role of drug dependence treatment in the prevention and care of HIV and AIDS, Interventions for Drug users in prisons, a guide to Good practice, and Sustained Recovery Management.

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## Acronyms

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
ATS	Amphetamine Type Stimulants
CBT	Cognitive Behavioural Therapy
CSW	Commercial Sex Workers
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
MDT	Mandatory Drug Testing
MI	Motivational Interviewing
MMT	Methadone Maintenance Therapy
NA	Narcotics Anonymous
NSP	Needle and Syringe Program, also known as Needle Exchange Programme.
NGO	Non Government Organisation
ST	Substitution Therapy
STI	Sexually Transmitted Infection
TC	Therapeutic Community
12 Steps	Twelve Step Fellowships
VCT/VCCT	Voluntary and Confidential Counseling and Testing
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund (formerly United Nations International Children's Emergency Fund)
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

## **Definitions in this document:**

**"Drugs":** psycho-active substances, whether they are legal or illegal. In this document drugs therefore includes alcohol.

**"Evidence based":** denotes policies and programmes that have been shown through evaluation or research to successfully achieve identified outcomes (i.e. reduced levels of drug use, reduced levels of offending, improved quality and standard of prison healthcare, improved workplace safety) while at the same time respecting or enhancing the human rights of people in prison.

**"Offender":** generic term for those who have broken the criminal law / code, used in this document when referring to offenders in the community and prison. When referring specifically to those in prison, prisoner is used.

**"Prisoner":** refers to adult and juvenile males and females detained in criminal justice and correctional facilities during the investigation of a crime; while awaiting trial; after conviction and before sentencing; after sentencing. Although the term does not formally cover persons detained for reasons relating to immigration or refugee status, and those detained without charge, many of the considerations in the Guide will apply to such situations.

**"Prison":** used to denote official places where people are deprived of their liberty, either awaiting charge, undergoing trial, awaiting sentence, following conviction and / or sentencing. Therefore in this document, "prison", can be read as including, "penal institution"; "custodial institution"; "correctional institution" and in some jurisdictions "jails".

## Introduction

The Working Group on Prisons identified a need for a document translating existing international guidelines into a practical tool to support the development of interventions for drug users in prison. The aim is to provide evidence and examples of drug dependence treatment strategies that constitute good practice in this area. It should be noted that many of the strategies outlined in this report apply to problematic and non-dependent drug use. Practical examples have been selected from across the globe to demonstrate that a wide variety of interventions can be implemented in diverse settings (including rural and resource constrained areas).

This Guide is aimed primarily at service providers and those responsible for services in prison. It will also be of interest to policy makers, commissioners and those with strategic responsibilities for prisoners, healthcare and drug dependency treatment.

We hope that this guide will be particularly useful for those:

- concerned with prison settings where there is currently little or no drug service provision;
- interested in developing or enhancing the capacity and quality of services;
- increasing the range of treatment options available.

This Guide shares examples of good practice and provides a broad framework to inform the planning, implementation and management of drug treatment in prison. It does not provide a set of step by step instructions on how to set up these services as this will vary, depending on whether the service/intervention is targeted at for example:

- prisoners awaiting trial or sentenced prisoners;
- the length of sentence being served;
- the type of prison and its security category ;
- whether the intervention is for male, female or young prisoners.

Interventions and services for drug users in prison are an essential component of public health care systems as prisoners are part of our community. Drug treatment services in prison, also increase staff awareness. The provision of such services may encourage prison staff to examine their own use of drugs, alcohol and tobacco as well as act as peer educators amongst other staff, their families and the wider community.

This guide does not address the issue of alternatives to imprisonment. It is internationally recognised that where possible drug users should receive

treatment rather than imprisonment<sup>1</sup> (UNODC/UNAIDS/WHO, 2006). Drug dependency should not be considered a crime. This guide focuses on the treatments that should be provided for those prisoners who develop drug problems in prison and/or where alternatives to imprisonment were not available or suitable.

Despite the complex task the group was committed to working towards ensuring that the guide was of relevance to differing national and cultural contexts.

#### Good Practice Statement

Treatnet defines 'good practice' as an umbrella term that encompasses evidence based and promising practices.

Evidence-based practices have been studied using appropriate scientific methodology and replicated in multiple geographic or practice settings. These practices produce specific, consistent outcomes and have been documented in scientific journals and frequently manuals.

Promising practices have been demonstrated to be effective, using objective measures, in one or more organisations. These practices may be at an early stage and show promise of replication, long-term sustainability and becoming evidence-based practices.

In addition, good practices should display the following features:

- Relevance to local needs.
- Ethical soundness.
- Sustainability likelihood (low cost, cost efficient, integrated, supported), and
- Replicability (sufficiently documented).

Source: Treatnet (2006)

Research and evidence based practice should inform and underpin the development of drug services in prison. However, it is also important to recognise that practices that are successful in one context do not necessarily translate to another setting. Therefore it is essential that the evidence base is

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<sup>1</sup> UNODC/UNAIDS/WHO (2006), *HIV/AIDS Preventions, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*; United Nations Standard Minimum Rules for Non-custodial Measures (Tokyo Rules), *UN Doc. A/45/110, Annex*: "Member States shall develop non-custodial measures within their legal systems to provide other options, thus reducing the use of imprisonment, and to rationalize criminal justice policies, taking into account the observance of human rights, the requirements of social justice and the rehabilitation needs of the offenders".

“interpreted” to reflect the “new” context and that in translating practices, account is taken of differing socio, cultural and economic factors.

Additional considerations when translating “best” practices in drug treatment to the prison context include: the legal position of drugs and drug use; national policies and regulations governing prisons and penal systems; the prison context itself; responses to drug-related offending; and the particular society’s attitude towards drugs, drug use and offenders.

We hope that the guide will also support the “translation” of existing international standards and guidelines (e.g. those published by WHO, UNAIDS, UNODC) into examples of realistic interventions that can be tailored to meet local needs. The Working Group in Prison identified that this “translation” was a potential barrier to service delivery in prison.

The Guide also includes interventions which do not require significant financial resources, as financial pressures were also identified as a potential barrier to service delivery.

The working group includes representatives of prison authorities and NGOs, with substantial experience of providing both abstinence based and harm reduction services in prison. Group members have also been involved in the strategic development and management of service provision on both a national and regional level. The ‘field’ experience and expertise of the Working Group and consultation with other colleagues has been central to the development of this Guide. We hope that our diverse international background has ensured that no one national model or approach dominates.

## Chapter One: Why work with drug users in Prison?

### **Prisoners experience drug problems before, during and after imprisonment...**

Various studies estimate that the percentage of individuals reporting problematic substance misuse is comparatively higher in prison than in the community. Different studies have indicated that the percentage of people in prison who have a drug problem ranges from 40 to 80% (Dolan K, Khoei EM, Brentari, C, and Stevens A (2008)).

Drug use amongst offenders entering prison is on the increase, mirroring the rising levels of drug use generally in the community (Stoever H, Hennebel L, Casselman J, (2004)).

Various explanations may account for the correlation between drug use and imprisonment. They include for example, where prisoners have:

- used and developed drug problems before they are imprisoned;
- developed drug problems in prison;
- offended to fund their drug use;
- used drugs to support and 'permit' their offending;
- used drugs after criminal activity or to cope with the consequences;
- been involved in criminal activity which brings them into contact with drugs;
- been imprisoned as using drugs is an illegal activity in a number of countries.

Most societies stigmatise drug use and attitudes towards offenders are also often hostile. Therefore drug using offenders and prisoners are considered as 'undeserving' of treatment and help, having brought the problems on themselves. Negative attitudes towards offenders and prisoners can be a barrier to the provision of services and interventions. In some countries drug use itself is a criminal offence<sup>2</sup> and therefore treatment is predominantly provided within the criminal justice system.

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<sup>2</sup> Whilst this is true, this document does not support the view that drug use should be criminalised.

"It has been estimated that in some countries around three-quarters of people in prison have alcohol or other drug-related problems, and more than one-third may be opioid dependent. Around one-third will have been imprisoned for drug-related offences. Some level of continued drug use often occurs in prison and is usually associated with high risk of HIV transmission due to sharing/reusing injecting equipment and drug solution. On release, prisoners with opioid dependence are at high risk of relapse and overdose. Consequently, substitution therapy is provided to inmates of correctional facilities in some countries. The costs of law enforcement, court time and imprisonment together contribute substantially to the social costs associated with opioid dependence. In general, studies indicate that pure criminal justice interventions, without associated opioid dependence treatment, have very limited impact on drug-using behaviour and re-offending among individuals with drug dependence."

WHO/UNAIDS/UNODC (2004), Substitution Maintenance Therapy in the management of opioid dependence and HIV/AIDS prevention: Position Paper

### **Prisons and prisoners are part of our community...**

Prisons provide an opportunity to promote public health through working with prison staff and prisoners. They also provide opportunities to engage with the wider community on issues of public health e.g. through prison staff, community agencies who work in prison and visitors.

Prisoners are members of our community, living in the community prior to imprisonment and returning to it upon release. They influence their social environment directly through their own interaction with the community and indirectly through their relatives and wider social network. Prison health is an inseparable and integral component of public health (WHO, 2003).

Individuals should not be denied drug treatment services because they are in prison. The denial of services should not be seen as part of any punishment.

"Imprisonment and other measures which result in cutting off an offender from the outside world are afflictive by the very fact of taking from the person the right of self-determination by depriving him of his liberty. Therefore the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation."

UN Standard Minimum Rules for the Treatment of Prisoners, rule 57

### **Prison health challenges do not ‘stay behind bars’...**

Prison health is not confined behind bars.

Prisoners are in daily contact with prison staff who return to their families and friends at the close of a day's work. Neglecting the health of prisoners may result in the transfer of prison health problems, including blood and airborne viruses into the wider community, just as community health problems come into prison.

A large percentage of prisoners serve short prison terms of less than one year. A significant number of these will reoffend and return to prison, creating a “revolving door” between prison and the community.

### **Addressing drug use reduces crime ...**

Prisons not only protect society by containing offenders but are also often tasked with helping them to lead law-abiding lives on their release. Drug dependency problems are a risk factor for both offending and re-offending<sup>3</sup> Good healthcare and drug treatment can reduce re-offending.

“In order to promote the social re-integration of drug abusing offenders, where appropriate and consistent with the national laws and policies of Member States, Governments should consider providing, either as an alternative to conviction or punishment or in addition to punishment, that abusers of drugs should undergo treatment, education, aftercare, rehabilitation and social reintegration. Member States should develop within the criminal justice systems, where appropriate, capacities for assisting drug abusers with education, treatment and rehabilitation services. In this overall context, close cooperation between criminal justice, health and social systems is a necessity and should be encouraged.”

Guiding principles of drug demand reduction, UNGASS 1998, para. 14

Therefore drug services in prison can often be more effectively “sold” within an agenda of crime reduction as opposed to health improvements for prisoners.

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<sup>3</sup> Correctional Services Accreditation Panel, UK see also Canada, Aotearoa/New Zealand and USA

"In many countries, limited resources are dedicated to prisons, and security often takes precedence over treatment and health needs. Balancing the security and safety needs of the prison authorities with the healthcare needs of the prisoners can be difficult. Yet through the provision of effective drug treatment, prisons can have significant impact in reducing the health-related and criminal impacts of dependent drug use, and can also reduce prison management problems as more prisoners take on treatment, rather than being involved in continued drug use and dealing."

Dolan K, Khoei EM, Brentari, C, and Stevens A (2008) *Prisons and Drugs: A global review of incarceration, drug use and drug treatment*, Beckley Foundation Drug Policy Programme.

### **Interventions are taking place in prisons worldwide...**

The problem of drug use and the need to provide services in prison for drug users is a global concern. Good practice and innovation in treatment can be found across the world.

### **Prisons are increasingly overcrowded and pose health challenges...**

The number of people being imprisoned around the world is increasing and as a consequence prisons are rapidly becoming over-crowded<sup>4</sup>. Often inadequate mental health care and substance misuse services in the community contribute to the rising numbers.

Overcrowding is detrimental to prisoners' good health and can lead to problems such as stress, lack of privacy, increased security problems, restriction on activities/time spent out of cell and poor hygiene. Prison conditions themselves can pose a major threat to the health of prisoners and staff, and may exacerbate existing health problems. When such problems are combined with inadequate nutrition, limited access to and availability of health care, prisons can become a major public health and humanitarian challenge.

"Prisons are sites for illicit drug use, unsafe injecting practices, tattooing with contaminated equipment, violence, rape and unprotected sex. They are often overcrowded and offer poor nutrition, limited access to healthcare and high rates of airborne and bloodborne diseases."

Report on the Global AIDS Epidemic A UNAIDS 10th Anniversary Special Edition 2006 p119

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<sup>4</sup> For country and regions specific data, see the World Prison Brief 2006 available at ICPS website: [http://www.kcl.ac.uk/depsta/rel/icps/worldbrief/world\\_brief.html](http://www.kcl.ac.uk/depsta/rel/icps/worldbrief/world_brief.html)

Through the provision of services described in this guide, drug treatment can play a definitive role in addressing this health and humanitarian challenge.

### **Prisons have a high prevalence rate of illness, infection and disease...**

Though reliable data on drug use and infections in prisons is not always available, where such statistics exist (Stoever H, Hennebel L, Casselman J, 2004) the prevalence rate tends to be higher than in the community. In particular, rates related to mental illness, suicide, infectious diseases such as HIV, TB and Hepatitis are much higher (WHO, 2007); (WHO 2005)<sup>5</sup>.

A high percentage of new HIV infections in some parts of the world e.g. Eastern Europe are a result of injecting practices in prison. Drug use may also play a role in sexual relations and sexual violence amongst prisoner's e.g. South Africa.

### **There are drugs in prison...**

Prisons are 'secure' establishments and so the presence of drugs can be a difficult issue for prison authorities to officially acknowledge. However drugs are widely available in prisons throughout the world and people will always try to get drugs into prison<sup>6</sup>. When one route is closed, another will be found – drugs have been brought into prison in food; in baby's nappies; hidden on and inside the person; in dead birds (e.g. UK pigeons) and in oranges thrown over prison walls; hidden in books, shoes and magazines; and carried in by prison staff, prisoners and visitors alike. Addressing the availability of drugs in prison requires ongoing action through a comprehensive supply reduction strategy.

Security and increasing the detection of drugs is an essential element of any effective Drug Strategy. Measures to reduce supply and reduce demand are interrelated (Penfold C, Turnbull P, Webster R, 2005).

### **Prisons can target a 'hard to reach' group and provide access to services for them...**

For many drug users, imprisonment is often the first time they receive some form of healthcare and can access help for their drug problems. Marginalised people (e.g. minority ethnic groups, the poor, immigrants) are often over represented in prison. Therefore prisons provide an opportunity for health services to access clients that maybe more difficult to reach in the community. Initiatives begun in the prison can be the starting point for ongoing work in the community. See also Chapter Five: Addressing Equality and Diversity.

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<sup>5</sup> Sainsbury Centre for Mental Health [www.scmh.org.uk](http://www.scmh.org.uk)

<sup>6</sup> Denial of this reality can contribute to high rates of HIV transmission within the prison.

### **A “captive” audience...**

In many prisons accessing drug treatment services will provide “time out of cell” for the prisoner and a welcome change to prison routine. Initial imprisonment; inter and intra prison transfer; parole/early release ‘knock backs’<sup>7</sup> are all potentially ‘life events’ which might ‘push’ prisoners into considering the need for change and therefore provide opportunities for intervention.

### **It works...**

There is evidence that prison based work with drug users can reduce re-offending and drug dependency (Pearson and Lipton, 1999); (Mitchell, Wilson and Mackenzie, 2006). The need for and the associated advantages of providing services to drug users in prison has been acknowledged by many countries and has been translated into a variety of interventions, examples of which are given throughout this document.

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<sup>7</sup> Term used to refer to refusal of request for e.g. home leave, parole / early release etc.

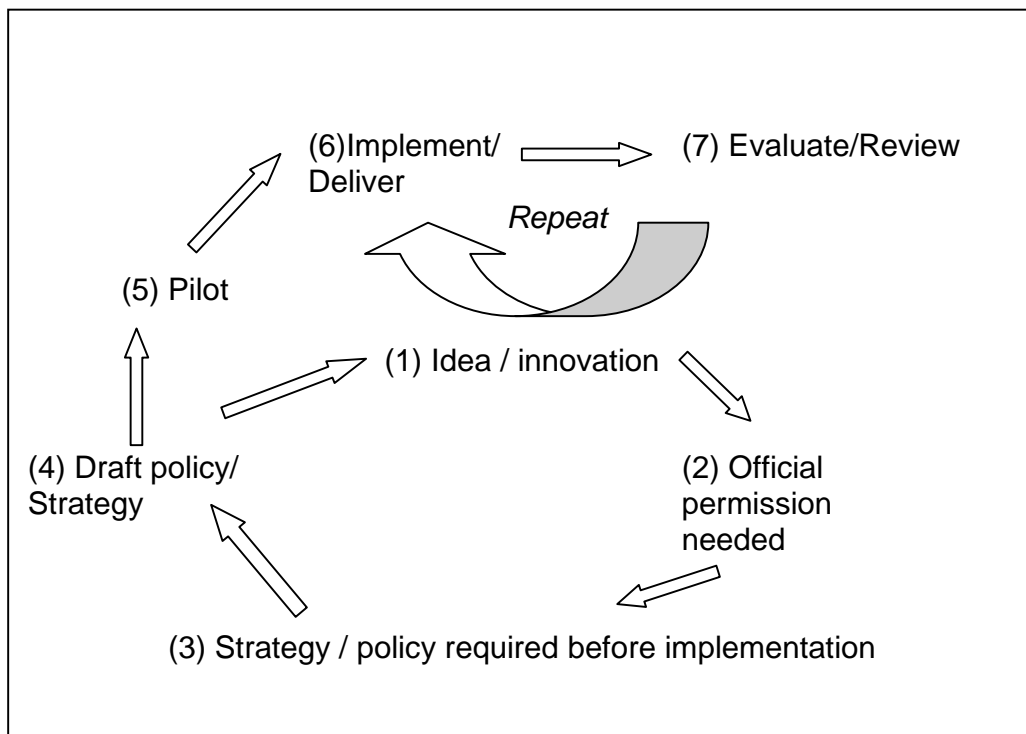
## Chapter Two: Developing a Prison Drug Strategy

### Starting out...

Medical care in prisons across the world is provided by different agencies, and through different systems and approaches, most often either under the auspices of the Ministry of Justice, Ministry of Interior, Ministry of Health or their equivalents.

Many countries in the world have a comprehensive and strategic approach to drug treatment in the community and prison.

A strategic approach to service development is essential to long term effectiveness:



However we can also become trapped in the first three phases of this cycle and consequently nothing is ever actually implemented.

Often the difficulties of providing services to drug users in prison can appear insurmountable. However working with drug users in prison provides a unique opportunity for intervention and innovation which do not necessarily require large scale financing.

In many countries much of the initial work and innovation began through pilot projects delivered without 'official' approval and/or funding.

Experience has shown that key to the effective implementation whether on a local, national or regional scale is a "can do" approach. A focus on barriers to implementation, such as the lack of a national strategy, insufficient finances etc, will prohibit service development. Internationally some of the most effective examples of good practice began because an individual or group of people (e.g. NGO, prison authorities, funders and policy makers) believed that something 'should' and 'could' be done in their prison(s). Initiatives were implemented and difficulties addressed during that process rather than trying to resolve all potential problems beforehand.

### **Who should be involved...?**

As many stakeholders as possible should be involved at the outset. Including them in the process will provide a forum in which concerns and problems (both actual and perceived) can be discussed. Stakeholder involvement will promote ownership and 'buy in' to the proposals.

Stakeholders might include:

- Prisoners with drug dependency;
- Prisoners with no history of drug dependency;
- Prisoners' families and friends;
- Prison managers;
- Prison warders;
- Healthcare services in the community and in prisons;
- Providers of local and national drug treatment facilities in the community and in prisons;
- NGOs involved in resettlement, rehabilitation, health and social care for prisoners in prison and specialist community services/initiatives for prisoners post release;
- NGOs involved in health and social care in the community;
- Probation and social services;
- Faith groups;
- Self help groups;
- Other community groups;
- Policy makers;
- Local and national government.

### **What might it look like...?**

A comprehensive and effective drug strategy must include elements of both supply and demand reduction.

Supply reduction initiatives are often more 'politically acceptable' on both a local and national level. Prisons are, after all, secure institutions. However there are drugs in prison, and there will always be people trying to get drugs into prison (see Chapter One: Why Work with Drug Users in Prison). In addition to standard security procedures, the use of CCTV, searching of staff and visitors along with the use of drug dogs may be included within a supply reduction strategy (Penfold C, Turnbull P, Webster R, 2005). Further information on such measures is beyond the scope of this document.

In terms of demand reduction, components of the strategy may include:

- advice and information services;
- drug education;
- pharmacotherapies – detoxification, withdrawal and maintenance treatments;
- risk reduction programmes;
- psychosocial programmes including family based initiatives – structured groupwork, counseling/psychotherapy and residential drug treatment programmes (also known as rehabilitation programmes or "rehab");
- drug free wings;
- physical activity and sports programmes;
- support groups.

An effective demand reduction strategy will encompass a broad selection of these components. As prisoners will be at different stages of change in relation to their drug use and since 'treatment' should be matched to individual need, a wide range of services is needed. However, if a prison/prison system is only able to provide some of these services then 'something is better than nothing'. Even where funding is minimal it should be possible to provide at least two of these interventions.

A multiagency approach involving a range of professionals, NGOs, community groups and prison staff is desirable. Effective demand reduction strategies require joint working and co-operation between prisons and external agencies (see page 82).

"The establishment of drug treatment services in a prison setting requires good support from the prison administration....There is a need for strong links between the programme and other aspects of the prison system to ensure and facilitate staff support and encouragement. Because of the complex nature of the problems associated with much of the prisoner population, successful programmes are most likely to be multi-disciplinary teams combining a range of different skills. There is a need for links with community services and ideally new services provided in prisons should be structured to draw in and link with community services...."

Farrell, M; Singleton, N; Strang, J (2000) *Drugs and prisons: A high risk and high*

Further discussion on intervention types and service delivery can be found in Chapter Three: Interventions in Prison.

#### **A question of Equivalence...**

International guidelines clearly state that those deprived of their liberty through imprisonment should retain their rights in relation to their health and medical care throughout their time in prison.

"Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal status."

*UN Basic Principles for the Treatment of Prisoners (1990)*

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"All prisoners have the right to receive healthcare, including preventative measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality".

*WHO (1993) Guidelines on HIV infections and AIDS in prison*

Therefore all detained persons have the same right of access to medical/healthcare services and professional standards of care as is available in the community. Internationally this is known as the **principle of equivalence**.

According to this principle the same treatment options should be offered in prison as in the community. In addition any treatment a person has received

in the community should be continued during imprisonment and upon release and vice versa.

The principle of equivalence is about more than services in prison simply being equal to those in the community. Given the disproportionate numbers of drug users and the prevalence of HIV/AIDS, Hepatitis, TB etc in prisons, the range and quality of services provided should arguably be higher than that in the community.

'Prisoners' are not a homogenous group. Women, young people, prisoners with disabilities, those with mental health problems, the elderly, migrants, minority ethnic groups and lesbian, gay and bisexual prisoners all have specific needs in relation to ensuring they are able to access 'equivalent' healthcare and medical services. (See also Chapter Five: Addressing Equality and Diversity).

One cautionary note regarding the principle of equivalence concerns the issue of equivalent to 'what' where no services are available in the community. The absence of community services does not negate the responsibility to provide services for drug users in prison. In a number of countries the prison service has led drug service development. Arguably the principle of equivalence applies in reverse.

### **What about confidentiality...?**

Openness and transparency between stakeholders regarding confidentiality and any actual or perceived conflicts is essential. Stakeholders will have different perceptions of confidentiality. Discussion and explanation of the rationale for the confidentiality protocol to be adopted is important if the policy is not to be 'ignored' or undermined. This will include addressing any concerns of, for example, prison staff and drug treatment professionals.

Any policy or protocol should also make explicit the sanctions for any staff, agency or organisation found to be in breach of the agreed confidentiality policy.

Prisons are secure institutions and working within a prison setting inevitably places restrictions (in general terms) on confidentiality (WHO, 1993).

All staff and visiting professionals and organizations should expect to adhere to confidentiality requirements which might be different to those they are familiar with in a community setting. For example it may be required that confidentiality is breached when:

- there is a threat to prison security;
- a prisoner is at risk of harming themselves or another person;
- there is knowledge of an offence that is to be committed;

- disclosure is made regarding an offence for which someone has not been convicted;
- there is concern that there may be a risk of harm to a child;
- information is received relating to drug use within a prison.

This latter point may appear onerous to services which have no obligation to report such matters to the authorities when operating in the community. Drug use in prison is usually against prison rules. By implication the fact that a prisoner has drugs available to them means that there has been a breach in security. Prison staff commonly have an obligation to report any knowledge of both drug use and supply.

However in order to work effectively it is important for service providers to be able to talk with prisoners about using drugs while in prison. Therefore in many countries prison authorities have agreed that service providers (including medical staff, prison and external agencies providing treatment) do not have to report information regarding actual drug use by individual prisoners. However they are required to breach confidentiality and report any knowledge relating to the supply of drugs within an establishment. Both prison and external agency staff will require training to ensure that such approaches are understood. (See also Chapter Six: Management Issues).

In terms of confidentiality a distinction must be drawn regarding confidentiality in relation to a prisoner's health (this includes drug dependency issues). This must always remain confidential. People in prison have the same right to medical confidentiality as patients in the community. Therefore information relating to their medical treatment and care must be kept confidential and access only granted to those with appropriate authority. Confidential information may only be disclosed to a third party with the prisoners express consent.

"Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents."

WHO (1993), *Guidelines on HIV infection and AIDS in Prison* p7

Communal living arrangements and constant surveillance by staff contribute to the challenge of protecting prisoners' confidentiality. Every effort must be made to ensure that when accessing services a prisoner's confidentiality is not breached.

At the outset (i.e. on assessment) for any treatment or intervention, prisoners must be aware of the rules governing confidentiality and how these apply. It is good practice for a prisoner to sign a confidentiality form confirming their understanding of the policy. It is also useful to have a 'consent to liaise' section on the form, where a prisoner can be asked to give explicit consent for their 'care team' to disclose confidential information to named individuals e.g. community probation/parole officer.

As before prisoners have the same rights as any individual in the community to refuse to consent to the disclosure of information. Where this occurs refusal should not in itself necessarily prohibit treatment or service provision. However, it may have a significant impact on the type of service provided. The prisoner should be informed of the implications of their decision. Prisoners may have experienced prejudicial treatment as a result of their 'known' drug use and in some countries have been 'criminalised' because of it. Prisoner concerns should be viewed in this context, rather than judgements made regarding their motivation or willingness to engage in treatment.

### **What about drug testing<sup>8</sup>...?**

In some countries, the prison drug treatment framework is supported by Mandatory Drug Testing (MDT) programmes. MDT has normally three main objectives, to:

- deter prisoners from misusing drugs through fear of being caught and punished;
- supply better information on patterns of drug misuse in the prison(s);
- identify individuals in need of treatment.

Under MDT (e.g. UK), prisoners are subject to a random testing programme and prisons may be required to test a set percentage of their population at regular intervals. A positive test result or refusal by a prisoner to be tested may lead to loss of remission (i.e. where the length of time to be served in prison is reduced for 'good' behaviour) and/or loss of privileges (e.g. prisoners earn privileges which provide them with additional benefits above the basic prison regime such as time they can spend out of cell).

Drug testing can play an appropriate and important role in drug treatment programmes (see below).

However there are a number of potential problems with MDT, these include:

- detracting financial resources from treatment and prevention services;
- diverting staff time from treatment and prevention initiatives;

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<sup>8</sup> Originally urine testing, currently also includes saliva swabs.

- an adverse effect on the prison regime e.g. prisoner resentment of testing, and creating a currency in 'clean' urine within the prison;
- MDT may contribute towards a focus on 'non-problem' use of cannabis because of the prolonged period that cannabis can remain in the body compared with other drugs. It has been argued that MDT may, in fact, provide an incentive for prisoners to switch to the use of harder drugs, which are more difficult to detect<sup>9</sup>.

As a result of a positive MDT test prisoners may be mandated to enter treatment irrespective of whether they are drug dependent. Thorough assessment (see Chapter Three: Interventions in Prison) is a key tool in identifying appropriate interventions. Mandated treatment (often linked to the return of privileges or entitlement to parole etc) means that prisoners will enter and engage with treatment services because of the positive test result rather than any decision regarding help with their drug-related problems. In such instances it is important that motivational enhancement interventions support the development of internal motivation. (See Chapter Three: Interventions in Prison).

Voluntary drug testing is also used in a number of countries, particularly with reference to 'drug free' wings/units and drug treatment programmes where consent to regular drug testing may be a condition of participation (see Chapter Three: Interventions in Prison). Whilst there are various challenges in relation to drug testing, it is carried out in community drug treatment facilities. Drug testing can 'reinforce' motivation to stay away from drugs. The 'threat' of a drug test can also have a supportive function and contributes to the maintenance of a drug free environment.

Practical considerations:

- Implications for the right to privacy as test results are highly sensitive personal information;
- Confidentiality: there needs to be a clear system and process for both the administration and processing of tests;
- A 'secure chain of custody' is required to ensure that results are not open to challenge as being inaccurate and to avert the risk of potentially tampered samples;
- For the testing to have any validity there needs to be a clear process for the actual testing itself and administration of the tests. Testing must be random and unpredictable. Testing facilities must be searched before each test to check that no 'clean' samples have been hidden and adequate measures should be taken to ensure that the person being tested is not able to secrete a 'clean' sample;

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<sup>9</sup> Some drugs clear the human body in short time, others remain detectable for much longer. For example, smoked cannabis can be traceable for up to one month, while injected heroin or cocaine are traceable for a few days only.

- For prisoners who have experienced abuse, the urine testing process maybe particularly uncomfortable and difficult. Some prisoners may have difficulty in being able to comply with test procedures.

In addition, tests do not provide information on the detail of what, when and how a drug was used.

### **Should we test for HIV...?**

Injecting drug users (IDU's) are recognised as an at risk group for contracting HIV because of potentially 'unsafe' practices e.g. sharing injecting equipment. However, compulsory testing of prisoners for HIV is unethical and ineffective (WHO, 1993).

Voluntary testing<sup>10</sup> for HIV should be available to all prisoners and carried out only with their informed consent. Voluntary testing and counselling services are a useful first step in addressing HIV prevention, treatment and care in prisons. Such programmes have proven to be a cost effective and a valuable tool in resource planning. The goal of voluntary testing is not to identify those prisoners who are HIV positive for the purposes of segregation or discrimination. Effective voluntary testing programmes should include education and advice on health promotion and risk reduction while promoting and positively encouraging HIV testing across the whole population. It is essential that HIV testing is a confidential procedure so that the prisoner's privacy is not compromised<sup>11</sup>. Counselling and support (including the availability of local services and treatment) are integral to the process and information in relation to 'what will happen to me if I am positive?' must be provided at the outset (UNODC/WHO/UNAIDS, 2006)

### **What about staffing...?**

International experience supports the view that drug interventions should be managed by dedicated personnel. Multidisciplinary teams have been shown to be most effective and would include dedicated prison staff, medical and healthcare staff and specialist drug treatment service providers. These providers may be from the voluntary sector (i.e. NGOs) and/or public sector and should consist of both ex-drug users (ex-users) and nonusers.

Therefore both prison and outside agency staff, and peer educators may be involved in intervention delivery.

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<sup>10</sup> This section refers to voluntary testing as opposed to mandatory testing for HIV. Mandatory testing is usually counterproductive and is "unethical and ineffective" (WHO (1993), Guidelines on HIV infection and AIDS in prison p5), the issues are further discussed in Lines R, (2007) *HIV infection and human rights in prisons* in WHO (2007), *Health in prisons: A WHO guide to the essentials in prison health*, Geneva, Switzerland.

<sup>11</sup> International Compendium of Current Practices to Address Infectious Diseases in Prisons. The International Centre for Criminal Law Reform and Criminal Justice Policy, 2001 pg. 14

Staff training and development issues are discussed in Chapter Six: Management Issues.

### **Working with external agencies...**

Staff from agencies outside the prison (e.g. civil society; NGOs community-based organisations; self help groups) have a valuable contribution to make in developing and delivering prison drug services. The involvement of these groups can also provide important support to often over-extended and under-resourced prison health services. Community services establish important links to the community which are essential for follow up care on the prisoner's release. Additionally, staffs from outside agencies are often viewed as being more "neutral" and independent than prison staff. Therefore prisoners may be more willing to discuss with them issues relating to their drug use.

"...external organisations operating outreach activities (among injecting drug users) can conduct health promotion. Mainline, a health promotion and disease prevention organisation in the Netherlands, maintains contact with detained drug users by low-threshold counselling in prison settings. In individual meetings with inmates, health issues, risk behaviour and the risks of drug use are discussed. An important feature is that as an external organisation, Mainline is independent of the prison system and enjoys the trust of prisoners. Evaluation of their activities has shown: a high level of acceptance amongst inmates, prison staff and administration...."

Stover, H; and Weildandt, K (2007)

Understandably prison authorities and staff can be concerned about external agencies coming into a prison. The primary objective of any prison is security and 'outsiders' can be seen as a threat to this. However the development of protocols and appropriate policies can effectively guide joint working. The provision of training to both prison and outside agency staff can 'offset' any misunderstanding of roles, responsibilities and policies and brings benefits to both organisations.

See also Chapter Six: Management Issues.

## Chapter Three: Interventions in Prison

This chapter outlines services that have been offered successfully in the prison context. Were all the listed services provided, they would form a comprehensive treatment system. However there are few countries in the world where each of the elements described are available. Political, legal, social, cultural or economic factors may restrict the range of service provision.

Barriers to service delivery can also include a belief that a particular model of intervention is not possible in a prison and/or region. Whilst examples from North America and Europe often have the advantage of being more thoroughly researched, we recognise local examples can be more influential. Therefore as far as possible we have tried to provide an international perspective.

How we approach service provision in prison is key. If we think it is difficult/impossible/controversial, it will be. There is more commonality between services in the community and prisons than there are differences; it is after all essentially the same client group. However this is not to underestimate some of the contextual challenges or differing needs of prisoners.

This chapter focuses on how these services might be provided in prison, highlighting any specific considerations. The detail of “how” to deliver each individual intervention is beyond the scope of this document.

### Treatment principles

Principles of effective practice are widely documented and therefore not repeated in this guide.

Examples are:

- Drug Abuse Treatment Toolkit: Review of the Evidence Base – UNDOC<sup>12</sup>
- Principles of Drug Abuse Treatment: A Research Based Guide – NA, USA<sup>13</sup>
- Rehab – What Works? – European Association for the Treatment of Addiction<sup>14</sup>
- Treating Drug Misuse Problems: Evidence of Effectiveness – NTA, UK<sup>15</sup>

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<sup>12</sup> [http://www.unodc.org/unodc/en/treatment\\_toolkit.html](http://www.unodc.org/unodc/en/treatment_toolkit.html)

<sup>13</sup> <http://nida.nih.gov/PODAT/PODATindex.html>

<sup>14</sup> <http://eata.org.uk/rehab.php>

<sup>15</sup>

[http://nta.nhs.uk/publications/documents/nta\\_treat\\_drug\\_misuse\\_evidence\\_effectiveness\\_2006\\_rb5.pdf](http://nta.nhs.uk/publications/documents/nta_treat_drug_misuse_evidence_effectiveness_2006_rb5.pdf)

- Principles of Drug Dependence Treatment. Discussion paper - UNODC<sup>16</sup>

These principles should underpin any drug treatment delivered in a prison setting.

### **“What Works?” principles**

Account should also be taken of international research and the evidence base relating to work with offenders; these are commonly known as the “what works principles”<sup>17</sup>. The research evidences the need for interventions with offenders to address:

- Risk: the ‘intensity’ of the intervention should be matched to the risk of re-offending. Therefore prisoners assessed as having a higher risk of re-offending should receive the most intensive interventions and vice versa;
- Need: interventions should be targeted at risk factors for re-offending (also known as criminogenic needs). These risk factors, when targeted effectively, can be reduced thus reducing the risk of recidivism;
- Responsivity: this requires that interventions are matched to an offender’s learning style and personality characteristics and the characteristics of the therapist/counsellor. No single approach is effective when delivered in isolation, different models each with valuable techniques need to be drawn into a coherent integrated multimodal approach.

Interventions and programmes for offenders need clear structures and a framework for their management, including incentives and sanctions for participants. The structure and framework should be consistently monitored and managed by the staff team. Programmes/interventions also need to provide a prosocial treatment environment to reduce negative peer influences.

### **Mandated and voluntary treatment**

All interventions within this chapter may be “mandated” or “voluntary”. They may form part of an early release/parole plan; a sentence plan; or be a precursor to transfer and/or progress through a prison system. Compulsory

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<sup>16</sup> <http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf>

<sup>17</sup> Further information can be found on the websites of Correction/Prison agencies e.g. Aotearoa/New Zealand <http://www.corrections.gov.nz/public/research/effectiveness-treatment/>; Queensland [http://www.dcs.qld.gov.au/Resources/Proceedures/Offender\\_Management/documents/ofmappwh](http://www.dcs.qld.gov.au/Resources/Proceedures/Offender_Management/documents/ofmappwh) atworks.doc; and related websites e.g. Campbell Collaboration <http://www.campbellcollaboration.org>

(legally mandated) and coerced treatment are not necessarily the same. Few drug users enter treatment of any sort on an entirely “voluntarily” basis, there is usually something external “pushing” them into treatment e.g. a partner threatening to leave, threat of job loss, health concerns, desire to avoid a custodial sentence, authorities deeming a child to be ‘at risk’ and potential loss of custody of a child. Evaluations of those attending compulsory/mandated treatment (Wild TC, Roberts AB, Cooper EL, 2002) have shown wide variations in perceptions of coercion. Some drug users legally mandated to treatment do not feel coerced and it has been reported that drug users who ‘self-refer’ state feeling coerced especially by family members (Policin, DL; Weisner, C 1999). The role of any treatment is to build motivation and promote engagement with the service.

Note:

The services described in this chapter are presented in the order they might be delivered to a prisoner following his or her entry to prison. The interventions have not been ‘ranked’. Issues relating to the importance or sequencing of one intervention in relation to another are covered in the text. However, where injecting drug use is prevalent, needle exchange programmes are an essential first line strategy in preventing the spread of HIV and HCV within the prison setting. Second line strategies include the provision of bleach or other disinfectants (Stoever H, and Weildant K, 2007)

**Advice, information and accessing services in prison...**

Information on service provision should be available to all prisoners.

Not all prisoners with drug use problems are easily identifiable and many drug users will be skilled in ‘hiding’ their substance use. Therefore all prisoners on arrival in prison should receive information about the drug services available and as many access/referral points to these created as possible.

The provision of information and advice on risk reduction and how to access community services is particularly important for those prisoners serving very short sentences.

Where an induction programme<sup>18</sup> operates, a session could be provided on drugs which would include:

- information on the range of services available in the prison and local community;

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<sup>18</sup> Many countries operate induction programmes which all prisoners attend following their arrival in the prison. The induction programme introduces them to the facilities, programmes and services available in the prison and provides information on how to access these. The programme usually also includes information relating to prison rules, discipline and complaints procedures.

- confidentiality issues including, where agreed, the lack of disciplinary sanctions for disclosure of a drug problem (see page 21) ;
- risk reduction information including blood borne viruses e.g. HIV, HCV, hepatitis A and B;
- overdose awareness including the dangers of restarting drug use after a period of abstinence when tolerance may be lowered.

#### **Example: Slovenia**

A health education programme is provided for all staff and prisoners. Information leaflets are distributed amongst the prisoners. These leaflets include information on personal hygiene and cleaning of living quarters. Staff are informed of infection control measures. Information and awareness campaigns on HBV and TB are carried out. Vaccination against Hepatitis B and TB screening is available for prisoners and staff.

A number of Prison and Correctional Services have introduced Information Packs.

#### **Example: Austria**

Since 1998 in Austria each prisoner is given an 'Information & Care pack' at the beginning of imprisonment. The pack consists of an information folder, condoms and a leaflet on services and risk behaviours.

Service information and access points need to be available beyond the initial stages of imprisonment as some prisoners will not be ready to engage in the early stages of their imprisonment and some prisoners will develop drug problems during their imprisonment.

Information should be clearly displayed throughout the prison, in Healthcare areas and other departments e.g. Education, Gym and Work centres.

Such information should take into account:

- literacy needs;
- relevant languages and cultural appropriateness;

and describe the types of services provided, who provides the services and how you access them.

#### **Assessment**

Assessment services identify prisoners who require a drug treatment intervention and the suitability of a specific intervention for the individual

prisoner. Assessment is an ongoing process that evaluates both the prisoner's progress in treatment and the effectiveness of the intervention, which if it is "not working" can be changed.

Ideally, on arrival all prisoners should receive a general health assessment, including an initial assessment for drug dependency.

Referral for assessment may also be made as part of the sentence and/or release planning process; as a result of positive drug tests (e.g. MDT and VDT); as an element of medical treatment or by self referral. However a distinction needs to be made between assessment of risk in relation to substance misuse as a factor for re-offending and the suitability of a particular intervention. It is important that any assessment for a specific drug treatment intervention is carried out by a suitably qualified person.

Assessment services are often more effectively delivered when they are split into two elements.

The first element is a screening assessment, also known as initial assessment (e.g. UK) triage assessment (e.g. Iran). There are a number of countries where screening assessments are completed on all prisoners with identified drug use issues. The purpose of such screening is to:

- Identify the nature of the drug use i.e. what is the level of dependency recreational, dependent etc and in relation to which drugs;
- Identify any immediate risk including self harm, suicide etc;
- Provide initial advice and information in relation to risk reduction;
- Consider the likely length of stay in the particular prison to better prioritise need and reduce the likelihood of prisoners being unable to complete treatment;
- Identify the appropriate level of service to be provided and by whom.

These screening assessments are particularly useful in ensuring that each prisoner receives the appropriate intervention. Short term prisoners or those on remand/awaiting trial may need to be prioritised in order to ensure that their immediate needs are identified and steps taken towards meeting these.

Such screening can, for example 'screen out' recreational users and drug dealers without drug dependency problems.

Following a screening assessment a prisoner may be referred for<sup>19</sup>:

- a full assessment of his/her drug use;
- medical and healthcare services;

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<sup>19</sup> Subject to local availability.

- a prison drug programme/service
- a community drug programme/service (short sentence prisoners).

A full assessment should take place in order to:

- Assess the nature and extent of any drug problem<sup>20</sup>;
- Assess motivation to engage in treatment;
- Identify further needs (see below);
- Identify any co-existing problems (e.g. mental health issues);
- Identify health needs including blood and airborne viruses.

In delivering these services, assessors should:

- ensure that assessments are done 'with' and not 'to' the prisoner i.e. the most effective assessments are where the prisoner takes an active role in the assessment process;
- address diversity issues with all prisoners (see also Chapter Five: Addressing Equality and Diversity);
- recognise that prisoners may be 'reluctant' to disclose their drug use because of fear of consequences and 'distrust' of the system;
- be aware that a prisoner may not have disclosed full information about their drug use at a previous assessment, information may not 'match' information received from community services or from other professionals/services within the prison;
- ensure a thorough detailed assessment is undertaken;
- provide risk reduction advice and information (e.g. safer practices, overdose prevention);
- provide information on treatment options in prison and/or release in the community;
- provide information in relation to blood borne viruses, risk behaviours, virus transmission, testing and treatment.

Such assessment services should not be confused with assessment for specific drug treatment programmes (see page 49).

As with advice and information, assessment services should be available throughout a prisoner's sentence and not just during reception/the early

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<sup>20</sup> In some countries recognised tools are used for this purpose including DSM-IV; DAST (Drug Abuse Screening Tool); ASI. See also Evaluation of Psychoactive Substance Use Disorder Treatment Workbook Series 2000 (WHO) [http://who.int/substance\\_abuse/publications/treatment/en](http://who.int/substance_abuse/publications/treatment/en) and European Monitoring Centre on Drugs and Drug Addiction – Evaluation Instruments Bank <http://eib.emcdda.eu.int/>

stages of a sentence. Whilst many prisoners will enter prison with a drug problem, a number of prisoners will develop drug problems or relapse in prison.

Following a full assessment a prisoner may be referred<sup>21</sup> to:

- healthcare and medical services;
- structured groupwork programmes;
- drug treatment programmes;
- counselling and psychotherapy;
- support groups;
- other (non drug specific) programmes;
- other departments.

### **Drug Education**

Drug and Alcohol education should be offered to all prisoners at the earliest opportunity following imprisonment and thereafter on a regular basis. The following guidelines on HIV/AIDS education/prevention can also be applied to drug education. These were agreed in 1993 when HIV/AIDS was the main rationale for addressing drug issues and these principles still stand.

- all prisoners should receive information on HIV upon entry into prison, and education should continue during the prison term and in pre-release programmes;
- all prisoners through groups or on an individual basis should have an opportunity to discuss information with qualified people;
- written materials should be available to all prisoners and should be appropriate to the educational levels in the prison, be made available in a language and form that prisoners can understand, and presented in an attractive and clear format;
- prison staff should receive education about HIV during their basic training and at regular intervals thereafter;
- information should be consistent with that available in the general community e.g. posters, leaflets and mass media;
- prisoners and staff should be involved in the development of educational materials;
- prisoners and staff should be involved in the dissemination of information (peer education).

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<sup>21</sup> Subject to local availability.

WHO (1993), Guidelines on HIV Infection and AIDS in Prison UNAIDS Best Practice Collection: Key Material

Drug and Alcohol education may include:

- why people use drugs;
- the role of drugs in the particular society;
- 'how' drugs work in the body and the brain;
- health information and advice related to relevant drugs of choice and the negative consequences of prolonged drug use;
- health information and advice related to blood borne e.g. HIV, HCV and airborne viruses e.g. TB, availability of vaccination for hepatitis A and B;
- risk behaviours including safer using; safer injecting, safer sexual activities, tattooing, risks associated with fights and other situations where blood may be spilt;
- overdose prevention, including the risk of overdose when tolerance is reduced;
- treatment availability in prison and the local community, understanding options and their benefits, how to access services.

All information provided should be accurate and objectively presented, so that the individual prisoner can make informed decisions.

Practical demonstrations and opportunities for prisoners to practice skills are an essential element of drug education e.g. how to use condoms and lubricants, safer injecting practices and where no needle exchange programmes<sup>22</sup> are available, how to clean drug using equipment or a tattoo needle.

Drug education in prison needs to emphasise how to 'stay safe' in prison, and then how to 'stay safe' in the community. Prisoners should also be reminded that the skills they develop in prison are transferable to the community on release. One of the benefits of well designed drug education is that participants will pass information and skills onto their peers outside of any formal peer education programme. Drug education may also be peer-led; peer supporters/educators who are part of a well designed and structured programme and appropriately supervised can be effective message-carriers.

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<sup>22</sup> Needle exchange programmes are the most effective means of controlling blood borne viruses and lessening other health related injecting risks, see risk reduction section below at page 43

**Example: South Africa**

The Themba HIV/AIDS Organisation intervention in Boksburg Correctional Centre for young men is facilitated by young people from similar backgrounds to those in custody. They speak the same language (including current street slang) and understand and take account of local circumstances, ethics and cultural values, while correcting popular myths about the virus (HIV), demonstrating and discussing safer behaviours in relation to drug use and sexual activities and imparting correct biological and health information<sup>23</sup>.

Information should be accessible and take into account language and literacy issues.

**Example: Iran**

Many prisoners do not have sufficient education to understand printed materials properly therefore some prisons have easily accessible automatic telephone services which provide answers to frequently asked questions on drugs and HIV.

**Example: Brazil**

In the State of Sao Paulo comic strips featuring a character 'Vira Lata' (Street Dog), were distributed to prisoners as an educational tool to educate prisoners about HIV/AIDS. Vira Lata, an 'ex con' is seen in a series of explicit sexual adventures but is always seen using a condom.

See Chapter Five: Addressing Equality and Diversity for further discussion of diversity issues in relation to the design and delivery of drug education.

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<sup>23</sup> A review of the Integrated Youth Offender Programme  
<http://www.csvr.org.za/papers/papiyop/htm>

## Pharmacotherapy

Pharmacotherapy is the medically assisted treatment of drug dependency.

### *Detoxification Programmes*

"Detoxification is the process by which the individual is withdrawn from the effects of a psychoactive substance. As a clinical procedure, the withdrawal process should be supervised and carried out in a safe and effective manner, such that withdrawal symptoms are minimised. Typically, the individual is clinically intoxicated or already in withdrawal at the outset of detoxification. Detoxification may involve the administration of medication, the dose of which is calculated to withdrawal symptoms without inducing intoxication and is gradually tapered off as the individual recovers."

National Collaborating Centre for Mental Health (2007) National Clinical Practice Guideline Number 51: Drug Misuse Psychosocial Interventions<sup>24</sup>.

The use of detoxification usually applies to opiates, analgesics, alcohol and various prescription drugs. Amphetamine type stimulant users (ATS) have not commonly received medical assistance with detoxification (see Withdrawal Management). Librium, methadone, lofexidine and buprenorphine are amongst the common drugs used in detoxification regimes. Countries will have their own guidelines for best practice in addition to international guidelines e.g.

- Clinical Management of Drug Dependence in the Adult Prison Setting (UK)<sup>25</sup>
- Position Paper on Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention (WHO/UNODC/UNAIDS, 2004)<sup>26</sup>;
- Substance Abuse Treatment and Care for Women (UNODC, 2005)<sup>27</sup>.

For alcohol detoxification guidelines see:

- The management of harmful drinking and alcohol dependence in primary care Guideline No 74 (SIGN: Scottish Intercollegiate Guidelines Network, 2003)<sup>28</sup>

Physical detoxification is not normally effective long term if offered as a stand-alone treatment. It should be provided in conjunction with other services and support, e.g. support groups and care planning. For some prisoners

<sup>24</sup> available at <http://www.NICE.org.uk>

<sup>25</sup> Department of Health (2006) *Clinical Management of Drug Dependence in the Adult Prison Setting*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063064](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063064)

<sup>26</sup> [http://www.who.int/substance\\_abuse/publications/en/Position\\_Paper.English.pdf](http://www.who.int/substance_abuse/publications/en/Position_Paper.English.pdf)

<sup>27</sup> [http://www.unodc.org/unodc/en/treatment\\_toolkit.html](http://www.unodc.org/unodc/en/treatment_toolkit.html)

<sup>28</sup> Available at <http://www.sign.ac.uk/guidelines/fulltext/74/index.html>

detoxification will not be the preferred treatment (see page 39 Maintenance Therapy)

This section provides a broad overview of general detoxification principles. Detoxification and drug withdrawal is a major issue in custodial settings. Imprisonment often results in 'involuntary' withdrawal. Some prisoners will feel 'safe' enough to disclose their drug use and receive detoxification treatment and support. However detoxification programmes may not be available in all prisons and some prisoners may not feel able to access them. Where detoxification (and maintenance programmes), are inadequate or not available there is a correlation between suicides in prison and drug withdrawal<sup>29</sup>.

Models of service provision for detoxification include:

- residential drug treatment units in prison;
- admission to a prison hospital;
- out patient treatment with the prisoner remaining in their cell in the main prison.

Alongside medical specialists suitably trained staff should manage the detoxification programme.

During and following the detoxification process, prisoners may be motivated to access other services. Therefore it is important that appropriate onward referral options are provided. A major challenge is to ensure that treatment gains through in-prison detoxification are maintained afterwards and that prisoners have access to psychosocial services.

Auricular acupuncture, yoga and mindfulness practice have been used in conjunction with medical detoxification to support drug withdrawal. Auricular acupuncture may be particularly effective for some stimulant users (Santasiero RP, and Neussle, G, 2005).

In many prisons detoxification is provided only on admission and is not available during later stages of a prisoner's sentence. As prisoners may develop a dependency at any stage of their sentence access to and referral pathways for detoxification should be established for this eventuality.

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<sup>29</sup> (i) Suicide is Everyone's Concern, HM Inspectorate of Prison, UK (1999) <http://inspectors.homeoffice.gov.uk/hmiprisonsthematic-reports1/suicide-concern/> (ii) Unjust Deserts, HM Inspectorate of Prison, UK (2000) <http://inspectors.homeoffice.gov.uk/hmiprisonsthematic-reports1/suicide-concern/> and (iii) Palmer J, Special health requirements for female prisoners in WHO (2007) *Health in prisons: A WHO guide to the essentials of Prison Health*

#### *Withdrawal management of ATS users*

Pharmacotherapy is important for ATS users in order to alleviate their withdrawal symptoms e.g. irritation, agitation, insomnia, depression, apathy, anhedonia (a lack of joy) and fatigue. Sometimes the symptoms may be very severe and long-lasting, therefore it is important to control them effectively in order to avoid relapse, treatment drop out, self harm and suicide attempts. Sedative-hypnotics e.g. benzodiazepines are commonly used for anxiety and insomnia (Kamieniecki, G., Vicent, N., Allsop, S. and Lintzeris, 1998).

ATS users may also experience either acute or chronic drug induced psychosis.

#### **Example: Japan**

Substance-induced psychiatric disorder is the most common psychiatric disorder in prison (22.1% of all psychiatric patients in 2005). Priority is placed on the treatment of prisoners experiencing severe psychiatric symptoms as these prevent full participation in psychosocial interventions and make adjusting to prison life difficult. Anti-psychotic medications e.g. haloperidol are used to control psychotic symptoms.

Pharmacotherapy for ATS users should be provided in conjunction with psychological and/or behavioural interventions as part of the treatment package.

#### *Maintenance Therapy<sup>30</sup>*

Maintenance therapy refers primarily to the pharmacological maintenance of people who are dependent on opioids. It involves the prescription of opioid substitutes to reduce illicit drug use in order to minimise harm to the individual and others. Maintenance therapy is also a gateway for the prisoner to engage with other services.

"Drug-dependent prisoners should be encouraged to enrol in drug treatment programmes while in prison, with adequate protection of their confidentiality. Such programmes should include information on the treatment of drug dependency, and on the risks associated with different methods of drug use.

Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons."

WHO (1993), *Guidelines on HIV infection and AIDS in prisons* p6.

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<sup>30</sup> Also referred to as opioid substitution

Since the 1990's, following the development of maintenance programmes in the community, programmes have also been introduced in prisons. In-prison methadone provision is now available in Canada, Australia, Poland, Indonesia, Iran, New Zealand, Puerto Rico and the majority of Western Europe. In 2005 the World Health Organisation added methadone and buprenorphine to its Model List of Essential Drugs (WHO, 2005), as these were found to be the most effective form of treatment for opioid dependence (Dolan K et al 2003); (Kerr T, Jurgens, R, 2004); (Stoever H, Hennebel LC, Casselman J, 2004).

#### **Example: Indonesia, Methadone Programmes:**

##### Pondok Bambu Women Prison & Detention Centre

A methadone maintenance programme is available to those who have been in prison for at least two years or have been in methadone treatment immediately prior to imprisonment.

Trained staff assess the participants and dosage is matched to assessed need, typically this ranges from 15 – 180 mg. Clinic opening times and the timing of the dosage is also based on assessed need and prisoner preference. Doses may be increased based on ongoing assessment. Prisoners on the programme are regularly monitored and individual counselling is available.

##### Cipinang Drug Men's Prison

The programme is open to prisoners who have at least three months to serve and on release following referral from the prison able to access methadone maintenance programmes in the community. Participants are assessed by trained staff and dosage is matched to assessed need, typically this ranges from 20-160 mg. Doses may be increased based on ongoing assessment. Prisoners on the programme are regularly monitored. Individual counselling, group counselling and health education are provided to all prisoners on maintenance therapy.

Initially programmes were developed for drug dependent prisoners with HIV/AIDS, other infectious diseases and/or pregnant women. In many countries maintenance therapy is now available to prisoners outside of these groups. Research ((Dolan K et al 2003); (Kerr T, Jurgens, R, 2004); (Stoever H, Hennebel LC, Casselman J, 2004). has shown that maintenance programmes in prison can reduce:

- injecting risk behaviour through reductions in the frequency of illicit drug use;
- violence and criminal activity<sup>31</sup>
- involvement in the prison drug trade (Dolan K, Wodak A, Hall W, 1998).;

<sup>31</sup> reported by warders in Islamic Republic of Iran

- heroin use, drug injection and syringe sharing;
- the risks of transmission of infectious diseases, particularly HIV and Hepatitis C;
- recidivism and the likelihood of re-imprisonment; and
- act as a 'gateway' to a range of healthcare provision and various drug interventions.

Maintenance therapy reduces withdrawal symptoms and cravings. As with detoxification programmes the provision of these therapies should not be a stand alone treatment. They help to stabilise the prisoner, improve physical health, psychological wellbeing, providing both a 'cure' and a 'care' element for those prisoners who are not able and/or willing to pursue abstinence. Therefore they are an opportunity to avoid some of the damaging effects of their drug dependency for both themselves and others (Stoeve H, Hennebel L, Casselman J, 2004).

"A wealth of scientific evidence has shown that MMT is the most effective intervention for the treatment of opiate dependence. MMT has been associated with reductions in risk behaviour, illicit drug use, criminal behaviour, participation in sex work, unemployment, mortality, and HIV transmission. Many of the concerns raised about MMT have been shown to be unfounded. In particular, MMT has not been shown to be an obstacle to the cessation of drug use. On the contrary, MMT has been found to be more effective than detoxification programs in promoting retention in drug treatment programs and abstinence from illicit drug use."

Betteridge G, Jurgens R (2008) *Opioid Substitution Therapy in Prisons: Reviewing the Evidence* Canadian HIV/AIDS Legal Network, Canada<sup>32</sup>

Issues to be considered in implementing and managing pharmacotherapy in prison include:

*Assessment:* Detailed assessments are needed to ensure that only appropriate prisoners receive treatment. This is particularly important to prevent any incidence of overdose where the prescribed dosage is too high.

Prisoners should be involved fully in the assessment process. The prescription of the substitution drug should correspond to the prisoner's assessed need; a too low a dosage may lead to 'topping up' (i.e. of the substitution drug with another drug). Assessment of need is an ongoing process.

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<sup>32</sup> available at <http://aidslaw.ca>

**Example: Australia**

In prisons in New South Wales, the usual regime is to commence on 20 mg daily as one oral dose, and increase 5 mg every third day till 60 mg is reached. After four weeks, if the prisoner believes that he/she needs more, following a blood test to determine the level of methadone remaining just prior to the next dose, the dosage can be increased. The usual dose range is between 60 and 80 mg daily. While there are people on higher doses, this is usually due to increased tolerance determined by the blood levels as above, or due to the prescribing pattern of the person's outside doctor.

*Availability:* Where prisoners (especially short sentence prisoners) are on pharmacotherapies in the community, their treatment should be continued on imprisonment and throughout their time in prison. Liaison with community services will ensure that treatment is continued post-release. Similarly pharmacotherapies initiated in prison should be continued post-release. Prisoners should have access to pharmacotherapy whatever their stage of sentence.

**Example: Austria**

Maintenance therapies are available in all prisons in Austria and they are not limited by length of the sentence. It is possible for prisoners in any penal institution to continue pharmacotherapies initiated before imprisonment. They may also commence a new pharmacotherapy in prison or prior to release.

*Confidentiality:* Pharmacotherapies need to be administered in a confidential manner (see chapter two). In some prisons, confidentiality is promoted through locating all prisoners on pharmacotherapy programmes in one unit, or by delivering their drugs with other medications.

*Supervised consumption:* Consumption should be supervised and observed to ensure that

- the drug is taken correctly;
- the drug is taken and not, e.g. hidden or retained to be given at a later date to another prisoner and/or enter the illicit market within a prison.

*Security issues:* Where prisoners receive pharmacotherapies as "outpatients" appropriate security measures need to be in place e.g. searching prisoners as they come onto and as they leave healthcare areas. Such measures are important for the 'prison' and the 'prisoner', they form part of the prison's responsibility in preventing the flow of contraband and can help prisoners resist pressure from other prisoners to smuggle drugs back into the main prison.

### **Example: France, Buprenorphine Programmes**

Since 1996 buprenorphine has been the drug of choice for opioid maintenance therapy in France.

Buprenorphine is not easily absorbed if taken orally and is usually taken sublingually. However, it presents less risks of overdose, is longer lasting and can therefore be administered less frequently than methadone, e.g. on alternate days. Accurate supervision of buprenorphine, (which takes ten minutes before it dissolves under the tongue), takes longer than methadone.

The prisoner is monitored and observed by a nurse ( Stoever H, Hennebel L, Casselman J, 2004). Where a high number of prisoners are taking buprenorphine in order to maintain effective monitoring, a large number of health professionals are required. This raises the issue of how to balance the prescribing of the drug to those in need against a healthcare environment in which resources are limited and time is an important factor. In France this problem has been addressed by giving several days dosages to reliable prisoners.

*Protocols:* Clear protocols need to be established between prison departments. All relevant personnel should be aware of the criteria and guidelines for admission onto the pharmacotherapy programmes.

*Contracts*<sup>33</sup>: Contracts should be devised detailing the responsibilities and expectations of both prisoners and healthcare staff during the treatment. Prisoners should also be made aware of the potential consequences of any breach of this contract.

Best practices in the community can and should be applied to the prison setting e.g. Drug Misuse and Dependence: Guidelines on Clinical Management (UK)<sup>34</sup>.

### **Risk Reduction Programmes**

*The example of needle exchange programmes and disinfectants provided in this section may be applied to other drug using equipment where there is a risk of spreading infectious diseases, e.g. hepatitis C through saliva in pipes or blood in snorting equipment.*

For further information and guidance on HCV see also references<sup>35</sup>

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<sup>33</sup> Also known as treatment compacts.

<sup>34</sup> <http://www.dh.gov.uk/publications>

<sup>35</sup> For clinical guidance: [http://clinicalevidence.bmj.com/ceweb/conditions/ind/0921/0921\\_guidelines.jsp](http://clinicalevidence.bmj.com/ceweb/conditions/ind/0921/0921_guidelines.jsp),

for diagnosis: [http://nhshepfaceit.pepperio.net/Assets/Downloadablefile/hep\\_c\\_quick\\_ref\\_guide\\_for\\_primary\\_care.pdf](http://nhshepfaceit.pepperio.net/Assets/Downloadablefile/hep_c_quick_ref_guide_for_primary_care.pdf)

for factsheet: <http://www.who.int/mediacentre/factsheets/fs164/en/>

Internationally a significant percentage of those who use drugs in prison inject them. As needles and syringes are generally in short supply, it is likely that many prisoners will be sharing their injecting equipment with a number of other prisoners. The sharing of drug using equipment is a major risk factor for the transmission of blood borne viruses. The risk is compounded by the fact that in prison the cleaning of injecting equipment is difficult. The general need for 'secrecy', avoiding detection by staff and the lack of available full strength bleach also contribute to this. Outbreaks of HIV infection in prison, associated with injecting drug use, have been well documented (Choopanya K. et al. 2002), (Taylor A., et al. 1995)<sup>36</sup>.

Reusing needles and use of inappropriate needles is also a major risk factor for injecting problems such as ulcers and thrombosis, creating health problems for the individual.

*"The provision of access to sterile injection equipment for injecting drug users and the encouragement of its use are essential components of HIV/AIDS prevention programmes, and should be seen as a part of overall comprehensive strategies to reduce the demand for illicit drugs. The equipment is provided through a great variety of approaches categorized as needle and syringe programmes, the goals of which are that drug users have their own sterile injecting equipment and do not share it with others, that the circulation time of used needles and syringes is reduced and that used equipment is disposed of safely".*

WHO/UNAIDS/UNODC (2004) *Policy brief: provision of sterile injecting equipment to reduce HIV transmission* Geneva, Switzerland<sup>37</sup>

*'In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.'*

WHO (1993), *Guidelines on HIV infections and AIDS in prisons* <sup>38</sup>

### Needle Syringe (exchange) Programmes (NSP)

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<sup>36</sup> Among others, the case of Thailand, Scotland and Lithuania. See for example: Choopanya K., Des Jarlais D.C., Vanichseni S., Kitayaporn D., Mock P.A., Raktham S., Hireanras K., Heyward W.L., Sujarita S, Mastro T.D (2002), *Incarceration and risk for HIV infections among injecting drug users in Bangkok*, Journal of Acquired Immune Deficiency Syndromes, 29, 86-94; Taylor A., Goldberg D., Emslie J., Wrench J., Gruer L, Cameron S., Black J., Davis B., Mc Gregor J., Follet E., Harvey J., Basson J., McGavigan J., (1995) *Outbreak of HIV infections in a Scottish Prison*, British Medical Journal, 310, 289-292.

<sup>37</sup> Available at <http://www.who.int/hiv/pub/advocacy/en/provisionofsterileen.pdf>

<sup>38</sup> [http://whqlibdoc.who.int/hq/1993/WHO\\_GPA\\_DIR\\_93.3pdf](http://whqlibdoc.who.int/hq/1993/WHO_GPA_DIR_93.3pdf)

NSP are the most effective and efficient methods of reducing transmission of blood borne viruses and minimising the harm to the individual drug user (Lines, R et al., 2006)

NSP have been successfully introduced in prisons in countries such as Armenia, Australia, Belarus, Canada, Iran, Kyrgyzstan, Luxemburg, Republic of Moldova, Scotland (United Kingdom), Spain and Switzerland.

These programmes should be provided as part of a broader strategy. Such schemes rather than 'promoting' drug use provide a means to engage with injecting drug users. NSP encourage and promote access to other services, whilst supporting safer behaviours and reducing the risk to the individual prisoner, fellow prisoners, prison staff and the wider community.

In addition to clean needles; alcohol pads, filters, sterile syringes and other internationally recommended equipment should be provided.

#### **Example: Spain**

Needle exchange programmes were first introduced in Spain in 1998/9.

According to the *Spanish Ministry of the Interior and Ministry of Health and Consumer Affairs Guidelines for the implementation of prison needle exchange programs 2002*, needle exchange programmes do not increase, rather they reduce risk in prison. Illicit syringes (which are usually hidden and unprotected), are replaced by NSP syringes which are supplied with a rigid protective case. In the event of an accident, it is less likely that it would involve a used syringe because the prisoner would have most likely have exchanged it for a new one; and in the event that the syringe has been used, it is less likely that it has been shared, thus reducing the probability of it being infected. It will also be easier to identify the user and therefore preventive actions can be taken if necessary.

There has been no evidence from the Spanish experience that implementation of NSP leads to increased drug use. The provision of NSP has reduced risky injecting practices and has acted as a 'gateway' into other drug treatment options. In 2005, NSP was available in 33 prisons in Spain.

Different models have been used to operate NSP in prison, these include distribution by:

- nurses, physicians and/or prison medical staff on a one to one basis (hand-to-hand);
- automatic syringe dispensing machines;
- prisoners trained in peer outreach;
- external NGO staff working in prison.

In devising an appropriate model for NSP, the following factors need to be considered:

*Availability:* The facility should be available at relevant times. As prison drug use often occurs in the evening, a scheme operating only within the day (e.g. through healthcare) may not meet the needs of the majority of prisoners. There may also be issues of confidentiality and trust if the scheme is administered by prison or healthcare staff (see below). Automated dispensers provide the highest degree of accessibility although cost maybe a prohibitive factor. If there are technical problems with the dispensing machine or if access to it is frequently unavailable, prisoner confidence in the scheme maybe affected. Peer outreach provides an easily accessible scheme. Identifying suitable prisoners for this role will require careful consideration and monitoring in order to ensure that the scheme does not become susceptible to any bullying, gang activity etc. Training, support and supervision of peer providers will also be required.

#### **Example: Kyrgyzstan**

In 2002 a pilot programme provided injecting equipment to prisoners through medical wards and in locations that could not be seen by guards. Secondary exchange was also made available through a peer exchange programme; training was provided to prisoners who undertook this role. The pilot concluded that both methods for exchange were required.

In 2004 NSP was available in 11 prisons.

*Awareness:* Effective implementation is dependent on ensuring that staff and prisoners are aware of the scheme, its purpose, how it will operate and the expectations of both staff and prisoners. All prisoners and staff must be aware of the expectations around confidentiality.

*Security:* The support of prison staff may be easier to obtain for schemes where the prison maintains a degree of control over access to syringes. This control has to be balanced with the wider aims of the programme. Peer distribution or dispensing machines generally have a higher take up rate. If injecting equipment is easily available then there will be no need for prisoners to 'trade' needles. Contrary to initial concerns there is no evidence of needles having been used as weapons in prisons operating NSP (Lines, R et al 2006). Prisoners should be required to keep their injecting equipment in a preset location and available for inspection by prison staff. Where NSP is available there is no need for prisoners to attempt to conceal equipment.

*Confidentiality:* As a general principle prisoners should be able to visit and exchange syringes without revealing to other prisoners and staff that they are injecting drugs. Peer schemes can be operated without prison staff being aware of the names of prisoners accessing the service. Automated dispensers should be located in a discrete area where those using the facility are not

necessarily observed. Prison administered schemes operated in a generic healthcare setting with prisoners accessing the service at times when other medical services and appointments operate from the same location, also supports the maintenance of confidentiality.

#### International Evidence and Experience

The Canadian HIV/AIDS Legal Network study on 'Harm Reduction in Prisons and Jails: International experience' reviewed prison needle exchange programs in Moldova, Switzerland, Germany, Spain, Kyrgyzstan and Belarus and found that prison needle exchange programs can operate and do operate, in both well funded and in severely under-funded prison systems; in civilian prison systems as well as in military prison systems; and in institutions with drastically different physical arrangements for the housing of prisoners from single cells to barracks with eighty to one hundred prisoners in one location. Needle exchange programs are operating in male and female prisons, across all security classifications and all population sizes.

All evaluations have shown consistently positive results for the health of prisoners:

- sharing was greatly reduced in those prisons in which exchange programs were available;
- in five prisons where evaluation included blood testing, no new cases of HIV or Hepatitis C infections were detected;
- a decrease in fatal and non-fatal heroin overdoses;
- decrease in abscesses and other injection related infections;
- prison needle exchange facilitated referral to treatment programs.

Further there was no negative impact on the safety and security in any of the prisons. Needles have not been used as a weapon in the prisons where needle exchange programs have been established and there has been no reported increase in drug use and injecting. This is consistent with the evaluations of community based needle exchange programs.

Support from the prison administration and staff has been crucial. In these prisons, prisoners and staff state that these programs have indeed increased their safety.

Canadian HIV/AIDS Legal Network (second ed. 2006) *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience* – available at <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=184>

### Distribution of Disinfecting Agents

The World Health Organization's Guidelines on HIV Infections and AIDS in Prison recommends that bleach should be available in prisons where drug injection, tattooing and skin piercing occurs (WHO, 1993). The distribution of disinfecting agents is important in reducing the risk of transmission of HIV and hepatitis in prison.

However it is only a second line strategy to NSP as the effectiveness of bleach as a decontaminant maybe reduced in a prison setting because of limited access to the bleach, the time required to effectively clean equipment and the type of injecting equipment used in prison (often "home made" e.g. ballpoint pen cases) may make it more difficult to disinfect properly (Taylor A, Goldberg D, 1996). Where bleach is available it must be full strength household bleach.

A number of prison services distribute bleach kits and iodophore-based disinfectants. Concerns have been raised suggesting that the availability of such disinfectants not only condones drug use and/or illegal acts in prison but that it may encourage nonusers to experiment with drugs and/or injecting as well as pose security risks. Such fears have not been reflected in practice e.g. in Canadian prisons bleach has been available without any threat to security.

#### **Example: United Kingdom**

HMP Shrewsbury, UK<sup>39</sup>. Disinfecting tablets were made available to the whole prison for 'general purpose use', focussing on the use of tablets for cleaning equipment generally. This was considered to be one of the factors central to the success of the pilot. Further, representatives from across the prison were involved in the scheme's development. A multi-disciplinary steering committee, comprising of a governor, representatives from healthcare and the prison staff association, and drug workers oversaw the co-ordination and implementation of the scheme.

Alongside the provision of disinfectants, information (e.g. leaflets, workshops etc) must also be provided. Whilst disinfectants may reduce HIV, HCV transmission, they are not 100% effective. Therefore NSP are recommended and safer behaviours/practices should be actively encouraged.

### Condom Distribution

Although traditionally the emphasis with drug users has been on reducing the risk in relation to the sharing of injecting equipment, drug users are also involved in sexual activity and this too must be addressed.

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<sup>39</sup> Prison Health Newsletter, Issue 25 – Spring 2007

Condoms should be made accessible, easily available and free of charge to all prisoners:

- throughout their time in prison;
- on temporary release;
- pre-release.

#### **Example: South Africa**

Boksburg Correctional Centre outside Johannesburg allowed the Themba HIV/AIDS Organisation to distribute condoms as part of their programme<sup>40</sup>. The Themba intervention also included participants practicing how to use male condoms correctly. Such interventions have had clear results in reducing the transmission of HIV and other sexually transmitted infections (UNAIDS, 2006).

Despite social and cultural taboos it is important to acknowledge that sex between prisoners will take place. In many countries sex in prison between prisoners will be against prison rules, and in some countries same-sex sexual activity is illegal.

In Iran and a number of Central Asian countries meeting rooms are provided for husbands and wives (also known as conjugal visits). An unlimited supply of condoms is available in the meeting rooms and typically there are no security checks which would prevent unused condoms being taken back into the main prison.

#### **Psychosocial Programmes**

For the purpose of this section psychosocial programmes are defined as:

“Psychosocial interventions are any formal, structured psychological or social intervention with assessment, clearly defined treatment plans and treatment goals, and regular reviews (NTA, 2006) as opposed to advice and information, drop-in support or informal keyworking.”

National Collaborating Centre for Mental Health (2007) National Clinical Practice Guideline Number 51: Drug Misuse Psychosocial Interventions<sup>41</sup>.

Where possible, taking into account the individual's situation<sup>42</sup>, family and “significant other” involvement should be integral to all psychosocial

<sup>40</sup> A review of the Integrated Youth Offender Programme  
<http://www.csvr.org.za/papers/papiyop/htm>

<sup>41</sup> available at <http://NICE.org.uk>

<sup>42</sup> Where significant others and families are involved in antisocial/pro-criminal activities, drug use or have been the perpetrators of abuse or violence, alternative social support may be required. Where the prisoner has been the perpetrator, initial involvement of the family/significant other may be too difficult.

treatments in order to maximise immediate outcomes and reinforce the likelihood of longterm change.

Many countries require that offending behaviour programmes, including those targetted at reducing drug dependency, achieve accreditation with a national accreditation panel for correctional services. Evidence based practice and quality standards are essential for effective outcomes (UNODC, 2008).

### Structured Groupwork

Structured groupwork will usually focus on 'pre' and 'post' treatment issues. Therefore sessions may be provided within the main prison or in facilities such as drug free units. They can also function as a stand alone service.

Structured groupwork interventions may include for example:

- motivational enhancement: usually delivered via motivational interviewing, where workers make an assessment of client motivation levels and use appropriate interventions which support positive behaviour change. Pre treatment, this can enhance clients' readiness for change; post treatment, this can reinforce treatment gains and build motivation for sustaining changes on release ;
- relapse prevention: is an essential element of any drug dependency treatment. The emphasis is on training drug users to develop a range of skills to identify, anticipate, avoid and/or cope with high risk situations and triggers for relapse. Components would include managing cravings, preventing a "lapse" becoming a "relapse", rehearsing skills and developing relapse prevention/management plans, identifying and beginning positive fulfilling alternative activities, coping with stress and instilling a belief in the drug user's own self efficacy;
- prerelease: planning and preparation for release are partiucularly important for prisoners with drug dependencies given the high risk of relapse and overdose (see Chapter Four: Through and Aftercare). Pre-release work may include maintaining drug free status post release, overdose awareness/prevention and information on the range of community services available, including how to access them.

## Counselling and Psychotherapy Services

Counselling and psychotherapy services may be provided as stand alone services or in conjunction with other interventions.

“Counselling” is widely used to describe a range of interventions with different therapeutic approaches. A distinction should be drawn between “counselling” and the use of “counselling skills” in individual work e.g.

- formal keyworking and support work: where individual support in relation to drug dependency is provided by a nominated worker (this could be a member of prison staff, healthcare or NGO worker);
- careplanned counselling: where in conjunction with an assessment, treatment/care plan and regular care plan reviews, structured counselling is provided. Careplanned counselling can be delivered across a range of modalities including motivational interviewing, cognitive behavioural, person-centred, humanistic, gestalt, psychodynamic or the 12 step facilitation approach<sup>43</sup>.

Formal counselling should only be provided by suitably qualified counsellors.

Many drug dependent people have experienced trauma (e.g. child abuse, war, rape and violence). Drug use may have become a ‘coping mechanism’ for dealing with the trauma. Post traumatic stress disorder and self harm are also frequently reported. Once the physical aspect of drug dependency is treated, the psychological aspect must also be addressed. Some prisoners will require counselling and psychotherapy at the very early stages of treatment in order to promote engagement with services.

Where counselling and psychotherapy services are provided care must be taken with regard to the therapeutic approach used and the issues to be addressed. Prisoners will not normally have access to the same support networks and structures that would be available to them in the community. They may spend substantial periods of time locked in their cell, their movement may be restricted as well as access to services e.g. telephones and other support.

Further considerations should include:

- the availability and likely frequency of sessions;
- confidentiality including availability of suitable ‘counselling space’ and policy requirements in the prison e.g. these may restrict the service that might be offered;

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<sup>43</sup> NTA (2003) *Service specification tier 3: Care planned counselling* available at <http://www.nta.nhs.uk>

- the counsellor/therapist familiarity with 'prison' and the 'prison experience';
- the possibility of the prisoner being transferred to another prison or released before work is completed.

Long term in-depth counselling/psychotherapy is rarely appropriate for a prison setting. Exceptions to this include prisons with a specific therapeutic purpose where the core focus of the prison is on the provision of such services.

### Residential Drug Treatment Programmes

Abstinence based drug treatment programmes have been operating in prisons for over 20 years. Within a secure drug free environment they provide prisoners with treatment through group and individual work. Additional support can also be provided by fellow prisoners and staff. Such units operate in a similar manner to residential programmes in the community.

Various therapeutic models may be offered including cognitive behavioural and 12 Step programmes.

- Cognitive-behavioural residential treatment: the emphasis is on structured psychological interventions derived from a cognitive model of drug misuse where the emphasis is on the development of skills to stay drug free. Prisoners are taught a range of cognitive and behavioural strategies to remain drug free, develop new skills and an alternative lifestyle. Strategies include relapse prevention work (identification of triggers to drug use, high risk situations, coping strategies), and identifying dysfunctional thinking patterns, managing emotions and problem solving. The treatment typically involves other individual and group activities.
- 12 step based residential treatment: based on the AA model which assumes a biological or psychological vulnerability to dependency. The treatment goal is abstinence and prisoners usually work their way through the first five steps of the 12 step programme. The treatment typically involves other group and individual activities. Programme graduates will be expected to attend self help groups in prison and in the community on release.

Programmes often include elements of both the above approaches and may use therapeutic community structures.

- Therapeutic Communities (TCs) are designed to immerse the prisoner in a total rehabilitative environment. The community members themselves through "positive" peer pressure help each other to change and develop the necessary skills to remain drug free and engage in community

living. Programmes are usually multi-phased and residents move from one phase to the next taking on more responsibility for themselves and within the community. A key element of traditional TCs is the intense groupwork often involving confrontational methods. Each TC will offer its own combination of interventions.

In addition to the 'core treatment work' effective drug programmes have enhanced their outcomes by including:

- mindfulness practice; relaxation training; yoga, tai chi and gi gong to aid stress management, support relapse prevention/management and develop cognitive abilities;
- sports and physical activity: gym and sports sessions providing physical exercise for stress management; life skills rehearsal; team building;
- art and creative activities;
- community meetings;
- support groups;
- family involvement;
- drug testing;
- aftercare services.

### **Example: India**

#### Tihar Jail, New Delhi

Operates a modified therapeutic community in dedicated wings within the Tihar Jail. The programme is run by a local NGO (SAASRA ) in conjunction with prison authorities. The programme is based on the following principles: bringing the community into the prison; participative management and creating self sustaining communities within the prison. The community is called "New Delhi Model Parivaar", parivaar in English means family. The community is divided in peer groups or families of up to 25 prisoners, each group has a 'senior prisoner' and within each of the prison houses/wings there will be a number of families but each house of wing has its own head i.e. 'father/mother'.

Detoxification is available to prisoners on admission to the unit. The programme includes individual and group therapy, meditation, yoga and vocational training. Peer support is available in the prison post treatment.

Further information available from UNODC Regional Office for South Asia including [http://www.unodc.org/pdf/india/our\\_work\\_sa\\_prisons.pdf](http://www.unodc.org/pdf/india/our_work_sa_prisons.pdf)

### **Example: Aotearoa/New Zealand**

Care NZ in conjunction with the Corrections Service has established successful prison drug treatment programmes in one female and six male prisons across Aotearoa/New Zealand.

The programmes are designed to reduce re-offending through the delivery of drug and alcohol treatment programmes which support prisoners in identifying and addressing the causes of their offending as well as supporting their re-integration into the community post release.

Interventions include group and individual therapy, motivational enhancement therapy, cognitive-behavioural therapy, dialectic behavioural therapy, relapse prevention, social and life skills training. The programmes also include peer support and self-help groups.

The programmes are designed to take account of and be responsive to the needs of Maori prisoners.

Further information available from [www. http://www.carenz.co.nz](http://www.carenz.co.nz)

Issues to consider:

- *The most effective outcomes occur when the treatment matches identified individual needs.* Therefore it is important that the broadest range of treatment approaches is available. Whether delivered by the prison or outside treatment providers it is unlikely that a full range be provided within a single prison. Therefore therapeutic inter-prison transfer need to be available. Where this is not possible or there is only limited drug treatment available, careful consideration should be given to how to meet additional needs. For example, by creating a specific support group, providing access to 12 step/self help meetings or providing one to one support;
- Access to the service: are all prisoners able to access the service, or are there restrictions based on e.g. offence history, prison disciplinary record, length of time still to serve etc? Previous offending does not have to be directly related to drug use in order for treatment to be effective. Where prisoners have been using drugs in prison it is likely that they may have poor disciplinary records. When serious problem behaviours have occurred e.g. assaults on staff and other prisoners, rather than refusing the prisoner treatment, a target could be set for the prisoner to begin treatment following a six month 'incident free' period;

- Assessment of suitability for the programme must be made by programme staff and admission to the programme based on this assessment. Protocols and policies will be required to facilitate this process. Other departments/professionals working with prisoners may identify substance use as a risk factor to be addressed. However treatment providers must be able to work with prisoners in assessing the suitability of one treatment approach or another;
- What pre-treatment work is to be provided and what are the programmes expectations of prisoners pre-treatment?;
- The policy framework e.g. the unit rules, treatment contract including the process for those who find engagement difficult or drop out of treatment;
- The policy on lapse/relapse and how the programme will work with prisoners who relapse during treatment;
- What will happen to prisoners post-programme? Are drug free units available? What support is available to them?
- Staff training and support.

See also Chapter Six: Management Issues.

### **Physical Activity and Sports Programmes**

Fitness, sporting activities and using gym equipment are vehicles through which a variety of interventions may be provided.

‘Sport’ and ‘sporting facilities’ provide opportunities for communicating service availability, drug education e.g. through the display of posters and leaflets, and supporting life skill development. Such education tools can be particularly effective especially for male prisoners since the information is communicated in a ‘non-threatening’ environment and one in which prisoners may feel comfortable and less vulnerable. In order to maximise impact and ‘safety’ information should be displayed alongside healthy living and fitness information and not on a separate board.

Staff supervising sporting activities are often more “effective” communicators than medical or therapeutic staff. Not only can materials be discussed and delivered in the context of ‘fitness’ but in this non-therapeutic and non-medical environment prisoners may feel more able to ask questions and discuss concerns.

Physical activity and sports are effective in reducing stress and managing anxiety and depression (Hayes K, 2000) therefore they form an integral part of any drug treatment programme.

### **Example: United Kingdom**

*'Tackling Drugs through Physical Activity' – HM Prison Service Physical Education College*

Through this initiative a guidance manual was provided to all Physical Education (PE) Departments in Prisons in England and Wales. The manual discussed the role of physical activity and sport in drug treatment. Detailed suggestions were made as to how PE departments could become involved in the drug strategy in their prison. A matrix of PE based initiatives and drug treatment was provided, along with suggestions as to how these might be implemented.

#### **Examples:**

- fitness testing and introductory courses for prisoners attending detoxification programmes;
- well man/woman programmes introducing the importance of fitness, healthy eating, and activities such as stress management and relaxation;
- team sports and games as part of team building for groups on drug treatment programmes;
- emotion management skills rehearsal and practice through participation in sport;
- goal setting and management through fitness programmes.

#### **Support Groups including Self-Help Groups**

Support groups provide an opportunity for prisoners to support each other during different phases of drug treatment. These groups range from informal discussion groups to more structured sessions. They may be facilitated by staff, peers, NGOs or outside agencies. Support groups should be considered for prisoners:

- as part of detoxification programmes;
- on pharmacotherapy treatment;
- engaged in psychosocial programmes (e.g. abstinence and prison drug rehabilitation programmes);
- who have completed psychosocial programmes (e.g. abstinence and prison drug rehabilitation programmes);
- those awaiting release.

Peer led interventions have been highlighted elsewhere in this document and considerable guidance on setting up and running effective peer educations/support groups is widely available, see for example <http://www.jhsph.edu> and <http://commint.com> and <http://www.fhi.org>

Support groups may also be facilitated by outside organisations, these may include faith based groups and ex-prisoner organisations.

#### **Example: Japan**

The DARC (Drug Addiction Rehabilitation Centre) is one of the most active self-help groups in Japan. Japanese prisons invite the members of DARC into the prison to provide regular group sessions. DARC members provide peer education and support through regular group sessions on issues such as pre-release, DARC programmes encourage prisoners to become involved in activities both in prison and post release. Launched in 2005, 26 prisons were involved in the first year. DARC members now visit 75 prisons across Japan.

#### *Supported abstinence groups*

Abstinence based support groups should be made available to prisoners during and post-treatment. These may be provided, in conjunction with a community drug treatment provider. Prisoners who have completed treatment programmes (programme graduates) are often effective facilitators of such groups.

#### *12 Step Meetings e.g. Alcoholics Anonymous, Narcotics Anonymous*

Local AA and NA groups will come into prison and run AA and/or NA groups (12 Step Meetings). Depending on the locality and the size of the respective fellowships, CA (Cocaine Anonymous and other fellowship groups) may also be willing to organise meetings.

Usually each AA/NA area group will have a criminal justice link person. Prisons wishing to establish meetings should in the first instance make contact with them. AA/NA meetings are for individuals who consider themselves to have a problem with alcohol and/or drugs. Whilst it is possible (e.g. in open meetings) for those who do not consider themselves to have a problem to attend, many meetings are closed and for members only.

If organising AA or NA meetings in a prison, the prison should not expect that non-AA or NA members can be present in the meeting.

Where members of staff working in a prison are also members of 12 Step groups, in order to protect both their anonymity and maintain professional boundaries, it is suggested that they should not involve themselves with the meetings. Consideration should be given to ensuring the anonymity of AA/NA

members from the community coming into the prison, as well as the individual prisoners themselves who are attending.

As not all prisoners will understand their drug use through the 12 Step philosophy it is important that other support groups are also provided.

### **Drug Free Units / Wings**

A drug free unit is an area within the main prison set aside for prisoners who contract to remain drug free while living there. This is normally supported by drug testing.

Drug free units are for those prisoners who wish to live in a drug free environment away from the prison “drug scene”. They often operate and provide enhanced conditions to that of the basic prison regime, therefore location on such a unit is often a privilege. These units may also be used to house prisoners waiting to attend residential treatment in the prison or on release or prisoners who have completed prison based treatment programmes. The regime and activities on such units vary widely (Stover H, Weilandt C, 2007).

If a drug free unit is to be created consideration should be given to:

- expectations of prisoners and any conditions to be adhered to. These should be written up into a contract which all prisoners are required to sign;
- policies for managing any breach of the contract e.g. relapse policy;
- drug testing;
- access and allocation of prisoners to the unit. Ideally a mix of prisoners with and without past histories of drug use is desirable;
- services which may be provided e.g. self help/support meetings, structured groupwork etc;
- selection, training and management of prison staff and staff from outside agencies (see also Chapter Six: Management Issues).

#### **Example: South Africa**

Leeuwkop Prison, Juvenile Section – SA Corrections/UNODC/Khulisa (NGO); see <http://www.unodc.org/newsletter/en/perspectives/no02/page005.html> for overview.

Further information available from UNODC Regional Office Southern Africa

## Chapter Four: Through and Aftercare

"In order to promote the social re-integration of drug abusing offenders, where appropriate and consistent with the national laws and policies of Member States, Governments should consider providing, either as an alternative to conviction or punishment or in addition to punishment, that abusers of drugs should undergo treatment, education, aftercare, rehabilitation and social reintegration. Member States should develop within the criminal justice systems, where appropriate, capacities for assisting drug abusers with education, treatment and rehabilitation services. In this overall context, close cooperation between criminal justice, health and social systems is a necessity and should be encouraged."

Guiding principles of drug demand reduction, UNGASS 1998 para. 14

Through and Aftercare Services are an important element in ensuring that treatment gains made in prison are sustained on release. They do not necessarily have to be provided by prison or by outside agency staff who work in the prison on a permanent basis. Permitting community based agencies to enter the prison, meet and work with prisoners can be an important starting point for through and aftercare services. Small local initiatives have led to the development at a later stage of more comprehensive schemes.

### Definitions:

Throughcare: *the continuous assessment and assistance from the first contact with the criminal justice system.*

Aftercare: *any drug rehabilitation and / or social re-integration scheme or programme that actively assists prisoners after release from prison or during a staged release*

Fox A., *Prisoners Aftercare in Europe*<sup>44</sup>

### Throughcare

In many countries, throughcare services begin prior to imprisonment through the preparation of pre-sentence reports and liaison between clinical and social care agencies, and NGOs. In countries where there are no such systems, the development of throughcare services may begin with starting initiatives for drug users.

Throughcare entails the co-ordination of interventions and identifying who is responsible for ensuring that these are provided. For the drug using prisoner

<sup>44</sup> Fox A (2000), *Prisoners Aftercare in Europe*, ENDHASP Cranstoun Drug Services, London 2000.

throughcare involves the co-ordination of specific drug treatment along with offending behaviour interventions, so that treatment provided is coherent and logically prioritised e.g. urgent healthcare needs and detoxification, drug rehabilitation, other offending behaviour programmes.

Joint working, networking and liaison between agencies is essential for effective throughcare. Ensuring continuity of care requires joint working on a local and national level between those responsible for prisons, healthcare and social care both in government and civil society. Continuity and consistency in medical care and drug treatment before and during imprisonment and after release from prison is essential in supporting successful outcomes for prisoners with drug related problems<sup>45</sup>.

All interventions described in Chapter Three can form part of a throughcare package. Throughcare for the drug user in prison begins with an initial assessment of their drug use.

To support the throughcare package prisoners should be able to easily access information about community services available to them post release.

Pre-release preparation and education on risk reduction and overdose prevention should be incorporated into pre-release programmes (see page 34 and 43).

Ideally drug using offenders with short sentences should be diverted from custody and serve their sentence in the community. Where they do receive short custodial sentences, a 'fast-track' priority status for in-prison treatment and aftercare planning needs to be in place. Appropriate treatment is not always available for prisoners serving short sentences. Therefore they should be provided with information on services in the community, how to access them and where possible referral to them.

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<sup>45</sup> Fox A (2000), *Prisoners Aftercare in Europe*, ENDHASP Cranstoun Drug Services, London

**Example: UK Drug Intervention Programme.**

Introduced in 2003 the Drug Intervention Programme (DIP) is designed to get adult drug misusing offenders out of crime and into treatment. The scheme involves criminal justice agencies working closely with drug treatment providers. Contact is made with identified offenders at the earliest opportunity. Operating within a multiagency framework DIP services are able to ensure effective liaison between agencies to improve access to and engagement with drug treatment providers. DIP services include arrest referral, motivational enhancement, groupwork, 24/7 telephone point of contact, assertive outreach, support and advocacy.

Research, published by the Home Office in 2007, found that:

- Offending levels reduced following contact with DIP. The overall volume of offending by a cohort of 7,727 individuals was 26 per cent lower following DIP identification.
- Around half of the drug misusers who come into contact with DIP through the custody suite showed a decline in offending of estimated as 79 per cent in the six months following DIP contact.
- Offending levels increased following DIP contact for approximately a quarter of positive testers.

The research supports the use of the criminal justice system as one route for getting drug users into treatment. It also provides evidence regarding the role of semi-coercive approaches in improving engagement in programmes.

<http://drugs.homeoffice.gov.uk/drug-interventions-programme/>

Aftercare is the final component of effective throughcare. On release, prisoners face many challenges and pressures which increases the likelihood of them returning to old coping strategies especially drug use.

Released into the community without adequate housing, financial, or medical support prisoners are more likely to re-offend and are at increased risk of drug overdose. Appropriate aftercare programmes and support can help break the cycle of drug use, offending and imprisonment.

Aftercare may be offered as:

- 'Mandatory aftercare', which sees treatment in-built into the sentence through a staged-release programme. This usually involves some form of licence;

- 'Coerced' aftercare, which involves some form of incentive, such as early release for those who agree to undertake treatment, for example by serving the last part of their sentence in a residential drug-treatment facility;
- 'Voluntary' aftercare, which requires self-referral to treatment by the released prisoner.

Aftercare programmes are important in maintaining the gains made by in-prison drug treatment.

*"Effective in-prison treatment appears to require a continuum of care that takes the drug-involved offender from the institutional environment to the re-integrative processes of community-based initiatives. ... Only by providing quality aftercare following prison-based treatment will the impact of this programming be optimally realized."*

Inciardi, J.A., Martin, S.S., Butzin, C.A., Hooper, R.M., & Harrison, L.D. (1997)

They also reduce the incidence of relapse and post-release risks of overdose. Statistics (Seaman et al., 1998) demonstrate that this risk is significantly higher during the first two weeks post-release. A number of studies<sup>46</sup> record that the mortality rate of prisoners under post-custody supervision is three and half times that of the general population, and one-quarter of deaths occur within the first four weeks of release.

The main risk factors for overdose deaths after release are:

- injecting heroin;
- recent history of non-fatal overdose;
- longer injecting career;
- high levels of use or intoxication;
- high levels of alcohol use;
- low tolerance because of detoxification in prison;
- depression;
- a history of using combinations of drugs including benzodiazepines and/or alcohol;
- sharing injecting equipment (may be indicative of low concern about personal risk);
- premature exit from a methadone treatment programme;
- not being in a methadone or other treatment programme.

Easier access to services and improved liaison between drug treatment and mental health services in prison and the community, in conjunction with access to prescribing services can help to reduce the numbers of deaths. Therefore it is important to develop 'pathways' into community services for post release prisoners.

<sup>46</sup> [www.nta.nhs.uk/programme/drd2.htm](http://www.nta.nhs.uk/programme/drd2.htm)

A number of studies have shown that “in-prison” services are less effective if they are not followed up by appropriate aftercare. Aftercare programmes play a key role in providing released prisoners with the practical support necessary to help them continue with the changes initiated in prison. Recidivism and relapse rates for released prisoners who have participated in prison drug treatment programmes are slightly lower than for control groups that have received no treatment at all. However prisoners who complete both in-prison treatment programmes *and* who attend residential aftercare programmes have significantly lower rates of drug use and re-arrest (Inciardi, J.A., et al. 1997); Dolan K, Khoei EM, Brentari, C, and Stevens A 2008); (Mitchell, O; Wilson, D and MacKenzie, D 2006)

#### **Example: Netherlands**

It was identified that unless funded directly by the criminal justice system, many drug treatment agencies gave prisoners or ex-offenders low priority on their waiting lists. This problem was addressed by giving drug treatment agencies a probation task that is partly funded by the Ministry of Justice. Probation for drug users is managed not by regular probation officers, but by specially trained drug workers who work *in* prisons (employed by drug treatment organisations), but not *for* prisons.

Planning for release is an essential element of through and aftercare. In circumstances where there are a number of professionals involved in work with the prisoner, liaison between all parties is essential. With prisoner consent, information should follow the prisoner post release to the service provider so that identified needs may be met.

Where aftercare services are provided a high number of those prisoners making a community appointment fail to attend. In order to maximise service take up, contact in person, by phone or by letter between the prisoner and the service is necessary. Part of the release plan may also include service staff or volunteers meeting the prisoner immediately they are released.

In some countries, ex-prisoner organisations, will meet prisoners on release.

**Example: Sweden**

Formed in 1997, KRIS (Criminals Return into Society) provides peer support and mentoring to prisoner's pre and post release. KRIS operates around the principles of honesty, decency, solidarity, comradeship and abstinence from drugs. Members of KRIS will meet a prisoner on his / her release, provide support, assistance and introduce them to the local KRIS facilities and support network. Mentoring is provided by an established member of KRIS, the 'godfather/godmother' scheme includes 24/7 contact. Social events with KRIS members and their families are also organised.  
<http://www.kris.a.se/engelskasidan.htm>

Members of 12 Step Fellowships e.g. Alcoholics Anonymous and Narcotics Anonymous are also often willing to meet prisoners and take them to a meeting immediately post release.

Probation and social services staff may meet prisoners and take them to residential drug treatment services especially where this is a condition of any parole or early release licence.

**All prisoners including those with drug problems have a number of common concerns on leaving prison.** Prisoners may meet with prejudice when they try to find accommodation and employment.

*Accommodation:* Having somewhere to live is often a first priority. Assistance with this is essential to enable the released prisoner to settle and reintegrate into society. Having a permanent address in many countries is necessary in order to register for state benefits and access social and medical services. For some prisoners the provision of accommodation away from their former environment and social circle whilst not automatically ensuring that the individual stays drug free, may help them in living a drug and crime free life. Such schemes may include, for example, placing the person with a foster family in a rural area, helping them find training or employment with tied accommodation<sup>47</sup>, specialist half way houses or a place in an appropriate residential rehabilitation centre.

*Money and employment.* Gainful employment and/or training provide financial stability, support the development of self-esteem and can provide a new social environment with a structure and useful activities.

Some companies offer training courses and apprenticeships in prison. Education and vocational schemes, including support with job applications, writing curriculum vitae and interview techniques are also provided in a

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<sup>47</sup> Tied accommodation is where accommodation is provided as part of the training or employment package.

significant number of countries. Such initiatives enhance the likelihood of a prisoner securing training and/or employment on release and contribute to them remaining drug free.

**Example: Japan**

While in prison, prisoners are offered opportunities to take part in vocational training to earn vocational qualifications and licences. On release through the Comprehensive Employment Support Programme, (operated in partnership with parole and public employment security officers), prisoners can access consultations and employment support.

However, employers and training colleges can sometimes be reluctant to recruit ex-prisoners particularly in countries where there is high unemployment. In a number of countries incentives are provided to companies recruiting ex-prisoners.

**Example: Sweden**

In Sweden, attractive financial incentives for employing an ex-prisoner are offered to employers. In the first year, an employer who takes on an ex-prisoner is offered reimbursement of up to 80% of his or her salary. The compensation decreases incrementally over five years

'One-stop shops', or 'brokerage' services have been designed to provide a single place where released prisoners can access support, information and advice regarding a broad range of needs. These include financial assistance, medical care, housing and employment advice, advocacy and onward referral.

**Example: Austria**

Favoriten Prison, specialises in the rehabilitation of drug-using offenders, a project support prisoners post release was initiated by a group of psychology students. Funding was provided by the Federal Ministry of Justice. The Association for Probation and Social Work of Vienna provided a probation officer who coordinated and supervised a team of volunteers. Following a training seminar, the volunteers were to provide prisoners with support, pre and post release to help them to adjust to life outside of prison and provide practical support/advice. Prisoners, regarded this service as useful, and indicated that it had helped them prepare for and adjust to life upon release.

**Example: Sweden**

A prisoner has the option of choosing a lay supervisor rather than a probation officer for assistance and monitoring after release. The person chosen must meet eligibility criteria, such as having good standing in the community. Lay supervisors also receive basic training in their duties and responsibilities from the prison and probation service.

Successful programmes invariably are the result of good inter-agency cooperation.

"Most practitioners agreed that the ideal throughcare and aftercare package for released prisoners would include: carefully planned release; assertive and proactive engagement strategies; varied and flexible support programmes; a non-judgemental motivational approach; fast access to clinical services; stable housing; leisure and employment opportunities; and responsive, trained and experienced drug workers. Implementation of this demands mutli-agency co-operation, a central accountable worker to co-ordinate services based on each individual client's needs, and secure funding to meet demand."

Fox A, Khan L, Briggs D, Rees-Jones N, Thompson, Owens J (2005): *Through and Aftercare: Approaches and promising practice in service delivery for clients released from prison or leaving residential rehabilitation* London, UK<sup>48</sup> p25

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<sup>48</sup> Home Office Online Report 01/05

## Chapter Five: Addressing Equality and Diversity

### Why is it important...?

Addressing diversity issues in the design and implementation of interventions for drug users in prison is important because:

- ✓ Problematic drug and alcohol use cuts across gender, race, culture, religion, sexual orientation and other social identity factors in all societies;
- ✓ Most countries are becoming increasingly multicultural;
- ✓ The representation of people from diverse backgrounds within prison and correctional facilities is increasing;
- ✓ Of the over representation of minority groups and the likelihood of them having experienced discrimination<sup>49</sup> in some form prior to and during imprisonment;
- ✓ Treatment is not effective if it fails to address diverse needs.

In order to be effective interventions whether delivered in a community or prison setting must take account of and address diversity issues. Working effectively with diversity is about more than treating all prisoners equally and providing equality of opportunity in terms of service delivery.

Equality is not about treating everyone the same but about taking account of individual need and circumstance. Sometimes we need to go beyond (i.e. treat people unequally) in order to ensure equal opportunities as we don't all start out equal, where we are born, and who our parents are, our health status and our access to basic nutrition etc all affect how equal our opportunity is. The principles of equality and human rights often become confused. We all have a right to food and shelter, to be treated with respect and to have access to healthcare etc. That is our right as human beings. However we don't all start out equal in life.

Asher Services (Aotearoa/New Zealand)<sup>50</sup> - Diversity Training Course for Alcohol, Drug and Healthcare Professionals

### Addressing equality and diversity in service delivery...

Working within an anti-discriminatory framework<sup>51</sup> is a dynamic process and this must inform both the planning and the delivery of the service itself.

<sup>49</sup> Discrimination is the acting out of positive or negative attitudes that either advantage or unfairly disadvantage a person or group.

<sup>50</sup> <http://www.asherservices.co.nz>

<sup>51</sup> An approach which challenges unfair treatment of people when the treatment is based on a specific characteristic e.g. age, sexual orientation, minority ethnic group, disability, religion etc.

It is essential that services actively demonstrate providers' understanding of the diverse needs of their client group and that prisoners view the service offered as being relevant to their needs.

The following are suggestions for ensuring service delivery addresses equality and diversity:

- Service information includes a reference to a commitment to equal opportunities and working with diversity;
- Materials and posters displayed should be relevant to a wide range of groups (e.g. minority ethnic groups, different faith groups, lesbians gay men and bisexuals, HIV positive prisoners, Hepatitis C positive prisoners and those with literacy and language issues);
- Information on HIV and hepatitis is clearly visible;
- Use a range of images and materials (not simply images of injecting paraphernalia) so that all drug users see the service offered as relevant to them;
- Address equality and diversity with all prisoners during the assessment process. This will ensure those with concerns feel able to raise them from the outset;
- Use inclusive language throughout all aspects of service delivery e.g. defining 'family' so that it includes and recognises the diversity of family life including biological parents, step families, foster families and being cared for by an institution; recognise different spiritual beliefs and denominations within different faiths;
- Ensure that interventions are delivered in a way that is consistent with the individual's goals, values and life situation;
- Ensure that the person's spiritual beliefs and faith based community is recognised and integrated into the treatment plan;
- Monitor engagement and service take up by all sections of the prison community through comparison with the demographic breakdown of the prison. If certain groups are not accessing services where possible seek feedback from them, contact specialist agencies and community groups to seek advice on making the service more accessible and relevant;
- Staff should model inclusiveness through their attitudes and behaviour.

All staff will require training in relation to addressing equality and diversity, see Chapter Six: Management Issues.

*In this chapter specific issues relating to groups identified in the Handbook on Prisoners with Special Needs, UNODC (2008) are highlighted along with the needs of women and young people. This list is not exhaustive; there are other groups within the prison population e.g. sex offenders, prisoners from rural areas, violent offenders, life sentence prisoners and pregnant women who also have specific needs. Addressing equality and diversity is an essential component of treatment and effective service delivery.*

For further general information see:

- Handbook on Prisoners with Special Needs, UNODC (2008);
- Adapting Offender Treatment for Specific Populations<sup>52</sup>;
- Drug Misuse and Dependence: UK Guidelines on Clinical Management<sup>53</sup>;
- Development and Practice Report No. 8: The Substance Misuse Treatment Needs of Minority Prisoner Groups: Women, Young Offenders and Ethnic Minorities (Borrill, J; Maden A et al 2003)<sup>54</sup>

### **Working with prisoners with cognitive and physical disabilities**

"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." (Convention on the Rights of Persons with Disabilities Article 1)

This section refers to issues for prisoners with physical and learning/cognitive disabilities. As in the wider society prisoners with physical and/or cognitive disabilities are vulnerable and potentially face direct and indirect discrimination in prison. For those with substance use problems this may be compounded.

Prisoners with physical and/or cognitive disabilities must be seen as individuals and the nature of their specific disability will also impact on their particular needs.

Issues to consider include:

- Attitudes towards people with disabilities may affect their access to drug treatment services. It may be perceived as being too complicated or not possible to include them in a treatment programme;
- Do policies and procedures take into consideration the nature of different disabilities;
- Are access issues e.g. the persons ability to fully understand and consent to treatment requirements and environmental needs e.g. wheelchair access, tape recorders, interpreters, support for hearing, access to kitchen, toilets and washroom facilities, addressed in the design and scheduling of treatment services;
- The staff's ability to respond to any bullying or discrimination from other prisoners;
- Where there are difficulties with physical access to treatment areas, is additional help available e.g. the service being provided on a one to one basis in cell;
- Consideration needs to be given to the relationship and interactions between the particular disability, any prescribed medication for the disability and the person's non prescribed substance use;

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<sup>52</sup> <http://www.ncib.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.80571>

<sup>53</sup> available at [www.doh.gov.uk/publications](http://www.doh.gov.uk/publications)

<sup>54</sup> Available at [www.homeoffice.gov.uk/rds/prisons1.html](http://www.homeoffice.gov.uk/rds/prisons1.html)

- Is additional help available to support the prisoner in feeling safe and to maximise their engagement with different aspects of treatment;
- Persons with disabilities will have other diversity issues and may be members of more than one social identity group.

See also TIP 29 Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities (SCSAT 1998d).<sup>55</sup>

### **Working with foreign nationals**

See also Working with Minority Ethnic Groups.

“Foreign national prisoners refers to prisoners who do not carry the passport of the country of which they are imprisoned. This term therefore covers prisoners who have lived for extended periods in the country of imprisonment but who have not been naturalised, as well as those prisoners who have recently arrived in the country.” (forthcoming Handbook on prisoners with special needs, UNODC 2008)

Because of increased global mobility there are more foreign nationals being held in prisons worldwide. Although a significant number of foreign nationals are detained for drug related offences; this does not necessarily mean that they have a substance use problem. Some foreign national prisoners do require drug treatment services whilst in custody.

Issues to consider:

- Foreign national prisoners may be very isolated as they are more likely to be cut off from their families and communities;
- Families are unlikely to be involved in the treatment process and post treatment planning;
- Language barriers may exacerbate isolation and prevent access and participation in drug treatment services;
- A foreign national prisoner’s ability to participate in treatment interventions may be effected by the additional stress of the threat of deportation; awaiting the outcome of an asylum application or other processes within a legal system they are unfamiliar with;
- Where a prisoner may be deported or returned to their country of origin making a referral to or accessing community services may be more difficult. They may not even exist;
- Potential disruption to treatment where foreign nationals may be trying to return home to serve their sentence in their country of origin;
- While staff may have an understanding of the cultural needs of resident minority ethnic and indigenous peoples they may not have an understanding of other countries and cultural groups;

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<sup>55</sup> Available at [www.ncbi.nlm.nih.gov/books](http://www.ncbi.nlm.nih.gov/books)

- Foreign national prisoners will have other diversity issues and may be members of more than one social identity group.

### **Working with Lesbian, Gay and Bisexual Prisoners**

Whatever one's beliefs about the 'causes' of anybody's sexual orientation (e.g. genetic, birth order, prior sexual abuse, choice) and how that should be worked out in people's daily lives, lesbian, gay men and bisexuals are a marginalised group in all societies and therefore issues relating to their care must be addressed.

In some countries being lesbian or gay may be illegal and criminalised. Many lesbian, gay men and bisexuals live in fear of being exposed knowing that such exposure may result in being ostracised by their families, imprisonment, physical punishment and in some countries death at the hands of the state. An individual's sexual orientation is an essential part of who they are. Issues of sexuality and sexual orientation are important in drug treatment and should not be ignored.

Training is required to support staff in working competently with lesbian, gay and bisexual prisoners, recognising the importance of being inclusive and not assuming that everyone is 100% heterosexual.

Issues to consider include (Wechgelaar, H, 1997):

- Many heterosexual people take part in same-sex relationships within the prison context (often known as 'prison bent');
- Research shows that many lesbians, gay men and bisexuals "come out"<sup>56</sup> as a result of the treatment process. Alcohol and drug use may have been used to acknowledge one's sexual orientation to oneself, to support 'coming out', to hide one's sexual orientation, used to deny one's sexual orientation, to deal with shame and stigma. Alcohol and drugs also act as a social lubricant;
- Because of prior negative experiences many lesbians, gay men and bisexuals may be cautious in discussing their sexual orientation with professionals;
- Another reason for reticence is the perception that anyone working with the criminal justice system is part of a system which criminalises and discriminates against lesbian, gay men and bisexuals;
- The prison environment may not be perceived as a safe space in which to 'come out'. Additional support should be offered to discuss issues that the prisoner may not feel comfortable discussing in a group setting;
- There is evidence to show that lesbian, gay men and bisexuals have a higher level of drug use and longer drug using careers than heterosexuals;

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<sup>56</sup>Coming out is a process. It occurs initially when one acknowledges to oneself and to others that they are lesbian, gay or bisexual. Lesbians, gay men and bisexuals are forced to come out repeatedly due to heterosexism and the assumption that everyone is heterosexual. Coming out to self is one of the hardest steps and coming out to others has risks involved with it. See <http://www.odos.uiuc.edu/lgbt/resources/comingOut.asp>

- While HIV is increasing in the heterosexual population, there remains a disproportionate rate of infection amongst gay men, this is also true of other sexually transmitted diseases and hepatitis B. HIV infection rates are currently increasing amongst young gay men in many countries;
- Lesbians, gay men and bisexuals will also have other diversity issues and may be members of more than one social identity group;

See also:

- A Providers Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals (CSAT, 2001)<sup>57</sup>;
- Asking the right questions 2: talking with clients about sexual sexual orientation and gender identity in mental health, counselling and addiction settings (Centre for Addiction and Mental Health, 2004)<sup>58</sup>.

### **Working with prisoners with mental health disabilities**

"About 9 million people are detained in penal institutions around the world. At least half of these struggle with personality disorders, and 1 million prisoners or more worldwide suffer from serious mental disorders such as psychosis or depression. Nearly all prisoners experience depressed mood or stress symptoms" (Blauw E and Hjalmar J.C. van Marle Mental Health in Prisons)<sup>59</sup>.

There is significant literature on the co-morbidity of mental disabilities and substance use (see below).

It is internationally recognised that offenders with mental disabilities should not be held in prison. However for a variety of reasons many such offenders are detained in prison. People may also develop mental health issues whilst in prison and being detained in prison often exacerbates existing mental health problems.

Issues to consider include:

- Attitudes and competency of staff in the assessment and diagnosis of co-morbidity;
- The medical and psychosocial support available to enable prisoners to access and participate in drug treatment;
- The criteria for entering treatment should not exclude those receiving medication for mental illness;
- All staff need an understanding of the specific person's non prescribed substance use and their mental disability and how they interact in order to develop an integrated treatment plan;
- Treatment should take account of the relationship between the mental disability, medication for this and the person's nonprescribed

<sup>57</sup> Available at [www.samhsa.gov](http://www.samhsa.gov) (USA)

<sup>58</sup> available at [www.camh.net](http://www.camh.net) (Canada)

<sup>59</sup> In Health in Prisons: A WHO guide to the essentials in prison health (2007)

substance use. It is preferred that staff are trained in working with both substance misuse and mental disabilities;

- Staff competency in relation to the increased vulnerability and risk of self harm and suicide amongst prisoners with co morbid mental disability and substance use;
- Policies need to take into account and respond to the needs of prisoners with dual diagnosis. For example; do policies take account of informed consent issues and instances in which confidentiality might be breached where the prisoner is unable to give consent;
- Prisoners with mental disability are particularly vulnerable to bullying and abuse from other prisoners and staff. This includes more subtle forms of discrimination which may take place within the treatment setting e.g. interrupting the person or excluding them from group discussions or speaking for them;
- Is additional help available to support the prisoner in feeling safe and maximise their engagement;
- Prisoners with mental disabilities will have other diversity issues and may be members of more than one social identity group.

See also:

- TIP 42, Substance Abuse Treatment for Persons with Co-Occurring Disorders (CSAT 2005b)<sup>60</sup>;
- Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health (UK, 2002)<sup>61</sup>;
- Mind the gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems (Scottish Advisory Committee on Drug Misuse (SACDM) and Scottish Advisory Committee on Alcohol Misuse (SACAM), 2003);
- McMurran M (2006) Second Expert Paper: Dual Diagnosis of Mental Disorder and Substance Misuse The National Programme on Forensic Mental Health.

## **Working with Minority Ethnic and Cultural Groups**

The population of many countries consists of both majority and minority ethnic groups and indigenous people. Whilst in recent years significant attempts have been to ensure services meet the needs of minority ethnic groups, drug services have been criticised as being designed for white, male opiate users. A criticism all too often reflected in client statistics and research (Fountain J, Bashford J, Winters M, Patel K, 2003) indicates that ethnic minorities report that they don't see existing drug services as being relevant to their needs. In many countries members of minority ethnic groups may be over represented in prison.

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<sup>60</sup> Available at [www.ncbi.nlm.nih.gov/books](http://www.ncbi.nlm.nih.gov/books)

<sup>61</sup> Available at [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)

Issues to consider include:

- Different cultural attitudes towards drugs, drug use and drug users. For example the role and function of drugs in different cultures e.g. Rastafarians' perception of cannabis. Differing views on alcohol e.g. Islamic, Non-Conformist Churches (e.g. Methodists, Baptists etc) and Seven Day Adventist's;
- Have policies been written that are culturally appropriate and responsive?
- Are staff culturally competent? In order to promote engagement minority ethnic prisoners need to have confidence in those providing the service. Demonstration of cultural awareness and competence may be shown through use of language, appropriate expression of respect and the openness to learn more about a culture;
- Have cultural issues been addressed in service design and scheduling e.g. activities take account of Friday prayers for Muslim and Jewish prisoners and the impact of fasting for Muslim prisoners during Ramadan;
- Is the methodology and/or content culturally appropriate e.g. using groupwork rather than one to one work with south asian clients;
- The difficulties for minority ethnic prisoners disclosing deeply personal information in any context where the dominant group is in the majority and/or where the person working with them is from the dominant group;
- Is additional help available to support the prisoner in feeling safe and maximise their engagement;
- Members of minority ethnic groups will have other diversity issues and may be members of more than one social identity group. For example: In the UK, black women were less likely to seek help for emotional problems although they experienced the same levels of depression and anxiety as white women. The focus of treatment for black men and women should be crack cocaine rather than opiate use, even though relapse prevention strategies are the same (Borrill J, Maden A, et al. 2003)

See Also:

- TIP Improving Cultural Competence in Substance Abuse Treatment (CSAT)

### **Working with older people<sup>62</sup>**

The number of older prisoners with substance use dependency is increasing as drug use per se becomes more widespread. Many people in western countries began using drugs in the 1960's and 70's consequently if they are still using drugs they are now presenting as 'older' clients. The increase in life

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<sup>62</sup> Different countries will have different definitions of who is an older prisoner. In some countries it is those above the age of 50, in others it is 60 or 65.

expectancy is also increasing the proportion of older service users presenting at drug treatment services. Prison may also contribute to the more rapid onset of aging.

Issues to consider:

- Drug use is generally perceived as being a problem of younger prisoners and therefore treatment services have usually been developed in relation to the needs of younger adults;
- Older prisoners may have a very lengthy drug using career and it can be difficult for them to envisage the rest of their life without drugs or even see the point of stopping;
- Some older prisoners may have been on long term substitution treatment in the community and this may not be available within the particular prison;
- Older prisoners may be a target for bullying, intimidation and discrimination by prisoners and prison staff;
- Alcohol problems may be more widespread amongst older prisoners;
- Older prisoners may be more likely to have other health problems eg eyesight and hearing impairment. They may have health issues directly associated with long term substance use eg dementia or hepatic liver damage from Hepatitis B or C etc. They may also be taking medication for these health needs.
- An older person may feel additional embarrassment in relation to literacy and numeracy needs and actively avoid activities where these skills are needed,
- Staff may feel younger prisoners should have access over older prisoners to programmes;
- Concerns about dying in prison may place additional stress on older prisoners and impact on their ability to engage in programmes;
- Re-integration and access to appropriate community services can be more problematic for older prisoners as these services are often targeted at younger people;
- Older prisoners may have 'tried' drug treatment many times before and there may be some resistance to further participation. This can be particular problematic where participation in drug treatment is a condition of release;
- Peer education promotes the engagement of young offenders in treatment; the role of peer educators with older prisoners should be considered. Older prisoners may also become effective peer educators of other prisoners. Where they are life sentence prisoners, there may additional benefits to treatment services e.g. continuity of peer educators, in-depth understanding of the prison culture and positive role modelling etc;
- Older prisoners will have other diversity issues and may be members of more than one social identity groups.

See also:

- Treatment Issues Specific to Prisons (USA)<sup>63</sup>

### **Working with prisoners under sentence of death**

The United Nations Commission on Human Rights and other International Human Rights organisations are unanimous in calling for the death penalty to be abolished.

Prisoners under sentence of death are entitled to the same level of care, access to services and treatment as other prisoners<sup>64</sup>.

Issues to consider:

- The time that prisoners under sentence of death spend awaiting execution is often lengthy; there are long appeal processes and there is always the possibility of the abolition of the death penalty itself. Access to treatment services cannot therefore be denied based on the premise that the person is about to die;
- Any treatment should take account of the impact of a sentence of death on a prisoner and the implications for their physical and mental health, their ability to access treatment, the attitudes of general staff in relation to death sentenced prisoners, their "right to treatment" etc;
- Prisoners under sentence of death will have other diversity issues and may be members of more than one social identity groups.

### **Working with prisoners with terminal illness**

People with terminal illness in the community and in prison have medical and psychological needs directly related to their illness. They may also need additional psychological, medical and spiritual support in relation to the dying process and the prospect of death.

Internationally AIDS-related illnesses are one of the main causes of death in prison. There is still stigma attached to being HIV positive or "having" AIDS therefore prisoners may experience prejudice and discrimination and become even more isolated. Where the person is also a drug user both the stigma and resulting isolation may be compounded.

Issues to consider:

- What kind of specialist support from drug treatment providers may be given to substance using prisoners with terminal illness;
- The prisoners illness including experience of pain may affect their ability to participate in treatment (see below);
- Their presence in group settings may impact on other participants and the group process e.g. concern about contracting the illness, if

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<sup>63</sup> Available at [www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.81052](http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.81052)

<sup>64</sup> See forthcoming Handbook on prisoners with special needs, UNODC 2008 page 155

other prisoners have the same illness comparing their symptoms and disease progression etc;

- Effective pain management for both chronic and acute pain may be more difficult because of lower tolerance for pain and higher tolerance of analgesics. See also Pain and Substance Misuse: Improving the Patient Experience, a Consensus Document (British Pain Society, 2006<sup>65</sup>);
- Do policies and procedures reflect the needs of prisoners with terminal illness;
- Are staff able to address stigma, prejudice and fear;
- Prisoners with terminal illness will have other diversity issues and may be members of more than one social identity group.

### **Working with Women**

Whilst women prisoners share many of the concerns of male prisoners, they also have different experiences of prison and consequently differing needs.

Issues to consider include:

- A higher percentage of women prisoners compared to male prisoners have drug dependency problems (Palmer J, 2007);
- Women are more likely to lose the support of their partners during their time in custody;
- Women prisoners have a higher incidence of mental health problems;
- The care of drug dependent pregnant women must be informed by thorough assessment by suitably qualified healthcare professionals to ensure that any pharmacotherapy regime protects the health and well being of both mother and baby. See also Drug Misuse and Dependence: UK Guidelines on Clinical Management, Department of Health, 2007<sup>66</sup>;
- Women are commonly the primary carers of children and on reception into prison their first concern will often be the care of their children. Drug related issues are likely to be a secondary concern. This should not be taken as a lack of motivation on the woman's part to address their drug use;
- Many women have had negative experiences regarding official involvement in the care of their children;
- Women are more likely to await trial in custody, be sentenced to a period of imprisonment and tend to receive shorter sentences for similar offences than their male counterparts;
- Previous experience of violence, rape and abuse are usually higher amongst women than men;
- Women may have been involved in the sex industry and their drug use will often be linked to this;
- A higher percentage of female prisoners self harm;
- Women's drug use patterns are often different to men's, with a greater use of over the counter medicines and benzodiazepines

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<sup>65</sup> Available at [www.britishpainsociety.org.uk](http://www.britishpainsociety.org.uk)

<sup>66</sup> Available at [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)

- Women will have other diversity issues and may be members of more than one social identity group.

Factors such as these need to be considered in the design and delivery of services to women in prison. Effective multiagency working is essential in order to ensure the well being of both the female prisoner and any dependants.

See also:

- Substance Abuse Treatment and Care for Women, UNODC (2005)
- Palmer J, Special health requirements for female prisoners in WHO (2007) *Health in prisons: A WHO guide to the essentials in prison health*.

## **Working with Young People**

There are a number of specific issues when working with young prisoners<sup>67</sup> that are different to working with adult prisoners.

Issues to consider include:

- Drug use is part of youth culture and drug use per se does not necessarily mean that the young person will have a drug dependency problem;
- It can be difficult for young people to envisage a life/the rest of their life without drugs;
- Some young people will have developed drug dependencies by a young age, some may be recreational users only and other young people may begin to show indications of dependant use but at this stage they do not view it as such;
- Drug education should be provided to all young prisoners as not all of them will have experimented or used drugs prior to their imprisonment. Therefore there is an opportunity for prevention and risk reduction work;
- Interventions must take account of the maturity and stage of development of the young person;
- Peer educators are a valuable resource in promoting the engagement of young offenders (Borrill J, Maden A, et al. 2003);
- How to maintain their relationships with appropriate family and significant others;
- Young people will have other diversity issues and may be members of more than one social identity group;
- Interventions should be young people focused and integrated with other young people's service provision e.g. education, gymnasium etc.

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<sup>67</sup> Different countries will have different definitions of who is a young person. In this document we are referring to those under 21 years of age but some of the principles mentioned can equally apply to the 21-25 age group.

See also:

- WHO (2003) Promoting the Health of Young People in Custody;
- NICE (2007d) Community Based Interventions to Reduce Substance Misuse Among Vulnerable and Disadvantaged Young People<sup>68</sup>.

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<sup>68</sup> Available at [www.nice.org.uk](http://www.nice.org.uk)

## Chapter Six: Management Issues

This chapter provides a general overview of key issues for those involved in the management of interventions for drug users in prison. Each national corrections/prison service will have its own structure, policy and legal framework. Each individual prison will also have its own specific requirements. Therefore this chapter provides a general overview of some of the key issues.

Internationally, those concerned with the management of our prisons are faced with competing pressures and priorities.

"Prisons are faced with particular and complex challenges in maintaining control and providing care. They are faced with the challenge of reducing the supply of drugs entering prisons through visitors, staff and other routes. In a setting where there is potentially a high demand for drugs, particular problems of violence, intimidation and extortion can occur and can undermine the safety and integrity of the institution. Prison authorities need to maintain a steady vigilance to reduce the risks of trafficking, corruption and communal disorder and yet also have to provide humane conditions in which the prisoner population can live. The growth in the size of the prison population presents particular challenges and burdens to the effective running of establishments where additional workload resources are not always provided to back up the additional workload."

Farrell M, Singleton N, Strang J Drugs and Prisons: A High Risk and High Burden Environment in Shewan D, Davies J (eds) (2000) *Drug Use and Prisons: An International Perspective* Harwood Academic Publishers, Amsterdam: Netherlands

Whilst the prison context can be a challenge it can also provide a unique opportunity for health promotion, intervention and disease prevention providing access to 'hard to reach' groups (See also Chapter One: Why Work with Drug Users in Prison and Chapter Two: Developing a Prison Drug Strategy).

### A 'healthy prison'....

WHO Health in Prisons Project<sup>69</sup> has led the early development of the concept of a "healthy prison"<sup>70</sup>. It has since been developed by other bodies, notably

<sup>69</sup> See <http://www.euro.who.int/prisons>

<sup>70</sup> See: Mental Health promotion in Prisons Report on a WHO meeting The Hague, Netherlands 18-21 November 1998 available at <http://www.euro.who.int/document/E64328.pdf> and WHO (2001) Prisons, Drugs and Society: A consensus statement on principles, policies and practices Geneva, Switzerland

HM Inspectorate of Prisons in the UK who apply four key tests for a healthy prison<sup>71</sup>, i.e.:

- Safety: prisoners, even the most vulnerable, are held safely.
- Respect: prisoners are treated with respect for their human dignity.
- Purposeful activity: prisoners are able, and expected, to engage in activity that is likely to benefit them.
- Resettlement: prisoners are prepared for release into the community, and helped to reduce the likelihood of reoffending.

The “healthy prison” is now widely accepted as a definition of what ought to be provided in any custodial environment. The WHO (2007) *Health in prisons: A guide to the essentials in prison health*<sup>72</sup> updates this concept and outlines the “whole-prison” or “settings approach”. This describes the vision for a “health-promoting prison” which is based on a balance between and recognition of, the need for prisons to be “safe, secure, reforming and health promoting, grounded in the concept of decency and respect for human rights”<sup>73</sup>. The approach recognises the opportunity prisons present to provide services to prisoners and prison staff (see also Chapters One and Two). It also recognises the importance of:

- promoting health rather than simply providing health care;
- identifying management responsibilities;
- ensuring health promotion is integral in planning and practice within the prison and recognising that it is related to decency and human rights in a prison;
- identifying priority groups of staff and prisoners who may be most vulnerable and strategies to reduce the most harmful effects for them.

The provision of interventions for drug users in prison should be seen within the context of a whole prison approach to health promotion.

Further the effectiveness of any interventions for drug users will also be influenced by the development of strategies, practices and training to address issues such as bullying, intimidation and violence.

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<sup>71</sup> See <http://inspectors.homeoffice.gov.uk/hmiprisons/our-work/>

<sup>72</sup> see Hayton P; Protecting and promoting health in prisons: a settings approach pp15-20

<sup>73</sup> ibid see page 17

### **Ensure both demand and supply reduction issues are addressed...**

An effective prison drug strategy requires both demand and supply reduction measures (see Chapter One: Why work with drug users in prison?). Both elements of the strategy need to be co-ordinated and work together to achieve its broader aims. It is important that staff understand these aims and recognise the significance of confidentiality and the parameters of work of each "team".

### **Developing the strategy...from ideas into practice...**

The development of a strategy is more broadly covered in Chapter Two: Developing a Prison Drug Strategy.

In summary the key issues to be considered as part of any development and subsequent implementation include:

- Involve all stakeholders: prisoners, prison staff, families, partner agencies, community services, NGOs and faith groups;
- Foster collaboration, coordination and integration between staff, prisoners and outside agencies;
- Ensure policy commitment on a local, regional and national level;
- Identify a national and a local "champion" who will support and advocate on behalf of the work you are proposing and/or undertaking;
- Respond to the evidence base. Ensure that proposals reflect best practice and are also responsive to cultural and socioeconomic differences - look to build on and develop the current evidence base;
- Assess needs, plan how to meet these and establish pilot projects which will be evaluated and reviewed prior to a broader implementation;
- Develop an incremental approach to implementation so that any difficulties can be addressed at an early stage and 'what works well' replicated;
- Cost proposals in detail and allocate resources;
- Ensure adequate financial provision for staff training;
- Monitor and evaluate service delivery;
- Review the strategy and identify further developments.

### **Selling the Strategy...**

The provision of drug services in prison brings many benefits for prison staff, prisoners, policy makers and society at large. Benefits may include:

- Reduction in crime e.g. reduced re-offending rates for those prisoners successfully completing drug treatment programmes;
- Health improvements for prisoners e.g. less risk of infectious diseases, healthcare for current drug related illnesses, recognition of any underlying mental illness once drug free and improved diet, exercise, lifestyle.

- Health improvements for the community: any health improvements for prisoners means health improvement for the prison community and the community at large;
- Reduction in demand for drugs leading to improved 'safety' in prison e.g. a reduction in the number of assaults on staff, prisoners and the incidence of gang activity.

It is essential that the strategy, vision and goals are effectively communicated. Copies of international publications and/or location of information (e.g. website addresses) and copies of the local strategy must be made widely available to all staff working in the prison. In order for staff to be well informed and "champion" the strategy consideration should be given to holding information sessions and 'open days' at the services. Such transparency will aid effective implementation.

### **Working together...**

Bringing together all the groups who work on the different aspects of the drugs strategy is an effective means of ensuring joined up (multiagency) working and successful implementation and management of the strategy. At a management level this can be achieved through a Prison Drug Strategy Group. The membership of such a group may include:

- Senior Prison Manager with responsibility for drug strategy;
- Prison Managers with day to day responsibility for drug strategy delivery;
- Prison Healthcare Managers;
- Managers from civil society, NGOs etc providing drug services in prison and community;
- Faith groups – e.g. leaders of these communities;
- Psychologist;
- Probation/Social Work Manager;
- Independent Monitoring Board<sup>74</sup>.

Prison based drug treatment services must also be integrated both within the prison and with the wider community. This involves the development of joint working arrangements, information exchange and protocols to enable referrals to be made to prison based services from police stations, courts and community based healthcare and drug treatment providers. It will also support continuity of treatment for people moving in and out of custody.

Integrating provision in the prison promotes greater mutual understanding within the prison and will reduce the likelihood of any deliberate undermining of initiatives.

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<sup>74</sup> Independent Monitoring Board: a group of independent and unpaid ordinary members of the public. They monitor the day-to-day life in the establishment and ensure that proper standards of care and decency are maintained e.g. <http://www.imb.gov.uk/>

Greater integration with community providers will support the exchange of information on best practice, provide formal and informal training opportunities and support for prison staff.

### **Implementing the Strategy/Initiative**

At the implementation stage it is helpful for all staff working within the prison to attend a training session to inform them of:

- the aims of the strategy and proposed services/pilot;
- how these will operate;
- benefits to staff, prisoners and to the management of the prison.

Staff should be encouraged where possible to visit the service(s) as soon as they are set-up. Such measures build staff commitment and ownership of the initiative.

### **Training and Staff Development**

All staff involved in the delivery of a prison drug strategy will require training. This will include staff involved in intervention delivery and those working in other areas of the drug strategy e.g. security and healthcare.

Prison managers and other managers (e.g. healthcare and NGOs) should receive training to ensure that they interpret policy documents and guidance appropriately and that management decisions are consistent.

Staff involved in intervention delivery need the required skills and competencies for their role. Where there are national occupational standards staff working with drug users in prison should be required to meet these.

For prison staff (e.g. warders) training might cover drug and alcohol awareness; understanding why people use drugs; the specific society's attitude to drug use; their own attitudes and beliefs about drug use and appropriate skills to support their role (e.g. listening skills, how to refer to services);

Community drug treatment staff coming to work in the prison may need training in relation to understanding the prison environment and the 'prison experience'; confidentiality protocols, security issues and the implications of working within a secure setting. For example: Cranstoun Drug Services (UK) encouraged staff new to the prison environment to spend a day working alongside a prison warder in order to develop a broader understanding of 'prison life'.

Depending on the interventions to be delivered the staff training might also include:

- Introduction to counselling skills;
- Theories and Models of Intervention;

- Assessment skills;
- Care planning skills;
- Working with Diversity ;
- Motivational Interviewing;
- Risk reduction;
- HIV / Hepatitis Awareness;
- Overdose Awareness and Prevention;
- Relapse Prevention.

Working with drug users in prison will provide opportunities for career development and progression for all staff. It is important that all training is easily replicable as staff will leave and 'move on', therefore they will need to be replaced as quickly as possible.

### **Supervision**

Good practice dictates that staff providing interventions be supervised by an appropriately qualified person e.g. counsellors by a counselling supervisor, healthcare staff by a healthcare professional.

### **Protocols**

This Guide has emphasised the importance of delivering interventions within a multidisciplinary framework and the sharing of information is an essential element of this.

Protocols to support joint working between departments, the prison and outside agencies need to be established at the outset. They should clearly state the obligations and responsibilities of each team/department/agency. These should be signed, dated and regularly reviewed. Management meetings will ensure that such protocols are being adhered to and updated. An example of a protocol for multidisciplinary working can be found in Appendix A.

### **Policies**

Operating policies should be agreed between service providers and the Prison Drug Strategy Group. Policies are likely to include:

- Confidentiality;
- Treatment Contracts;
- Client Rights;
- Relapse Policy;
- Drug Testing Policy.

Confidentiality is discussed further in Chapter Two: Developing a Prison Drug Strategy. The principles outlined there should be used to guide the design of a confidentiality policy for use in a prison setting.

A Treatment Contract details the obligations on both the prisoner receiving or engaging in a service, the prison and the service provider.

A Service User Rights Statement details the rights of a service user (prisoner) including how to make a complaint in relation to the service provider. An example from the UK can be found in Appendix B.

A Relapse Policy guides the effective response and management of relapse. Behaviour change takes time and is rarely successful on the first attempt. Whilst not inevitable, lapse and relapse is a "normal" part of the change process. In an environment which is meant to be 'drug free', flexible responses to relapse and positive drug tests can be difficult to achieve. Therefore relapse policies need to provide both boundaries, to ensure that the safety of the treatment environment is maintained and flexibility so that the reasons underlying any relapse can be properly assessed and appropriately responded too. Example see Appendix C.

### **Further questions...**

In the management of interventions consideration needs to be given to:

- Location of services/information – can prisoners access the services without it being known 'what' they are attending for?
- Can services be provided as part of general healthcare facilities?
- Disclosure of drug dependency - who needs to know, how will this be recorded?
- Are prisoners able to disclose their prison drug use issues without the disclosure leading to punishment?
- Due to the legal status of drugs and/or drug use in a country, prisoners with concerns about their drug use may be reluctant to identify themselves to 'authorities'. It is recommended that agreement be reached and a policy adopted of not 'penalising' prisoners for disclosure of drug use and drug problems. This policy should be communicated to prisoners and all staff and may help alleviate prisoner concerns regarding such disclosure.
- Prisoner motivation and willingness to engage. Expect that prisoners will be 'externally' motivated (e.g. early release, prisoner transfer, parole etc) to attend for treatment. It is the service provider's job to support the prisoner in motivational enhancement (e.g. motivational interviewing). Treatment recommended by others 'can' work therefore prisoners with drug dependencies may be required to engage in treatment as part of sentence planning and/or early release/parole process.

### **Review and evaluation**

Evaluation of the strategy as a whole and its individual components is critical. Evaluations provide accountability, feedback, identify areas of practice that 'work' so that these can be replicated, as well as pinpoint areas for development.

The review of the strategy might include:

- The progress made in developing a “healthy prison” e.g. safety, respect, resettlement, health promotion;
- Have both supply and demand reduction initiatives been implemented? How are they working together?;
- The progress on developing and implementing the strategy;
- Working together: have all stakeholders been engaged? How effectively are they working together?;
- Selling the strategy and communication: are all staff aware of and supporting the strategy?;
- Outcomes from training, staff development and supervision: including has learning been transferred to the workplace? How has training improved staff performance? Feedback from staff in relation to the training. The implementation and effectiveness of supervision structures;
- Are relevant protocols and policies in place? Are staff aware of them and are they followed in practice?

Evaluation of individual components of the strategy:

For each intervention a clear model/approach, aims and desired outcomes are required in order to evaluate effectively. The effectiveness of prison drug treatment should be measured in terms of both behaviour change in relation to drug use and rates of re-offending (or prison disciplinary record where the prisoner remains in prison post treatment).

Each intervention evaluation should focus on:

- Implementation: including service and policy development, the service model, implementation plans, criteria for participation; programme components, treatment length, staff competence and training;
- Process: including assessment and admission; programme access (inc access by minority groups); completion rates; reasons for discharge; drug testing results; prisoner disciplinary records; level of service delivery (inc whether delivered at level/frequency intended) and operational constraints on service delivery;
- Outcome: analysis of outcomes in relation to drug use, criminal activity, social adjustment, health risk behaviours and cost. Methodology should include pre and post test comparison, including longer term follow up. Consideration should also be given to longitudinal studies and randomised controlled trials.

In some countries as part of accreditation, standardised psychometric tests are used to measure outcomes against criminogenic risk factors.

See also: WHO Evaluation of Psychoactive Substance Use Disorder Treatment Workbook Series 2000<sup>75</sup> and European Monitoring Centre on Drugs and Drug Addiction: Evaluation Instruments Bank<sup>76</sup>

### **Checklist...**

A checklist for governors and managers of prisoners can also be found in WHO (2001) *Prisons, Drugs and Society: A consensus Statement on Principles, policies and Practices* Bern, Switzerland pages 24-26.

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<sup>75</sup> available at [http://who.int/substance\\_abuse/publications/treatment/en](http://who.int/substance_abuse/publications/treatment/en)

<sup>76</sup> available at <http://eib.emcdda.eu.int/>

## Chapter Seven: International Guidelines

### **Selected legal obligations, commitments, recommendations, and standards on HIV/AIDS, prison health, prison conditions, and human rights:**

- Universal Declaration of Human Rights [1948]
- United Nations Standard Minimum Rules for the Treatment of Prisoners [1955]
- International Covenant on Civil and Political Rights [1966]
- United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [1982]
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) [1985]
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [1987]
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment [1988]
- United Nations Basic Principles for the Treatment of Prisoners [1990]
- United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules) [1990]
- United Nations Guidelines for the Prevention of Juvenile Delinquency [1990]
- World Health Organization's Guidelines on HIV Infection and AIDS in Prisons [1993]
- Joint United Nations Program on HIV/AIDS (UNAIDS) Statement on HIV/AIDS in Prisons [April 1996]
- Recommendation No R (98)7 of the Committee of Ministers to Members States Concerning the Ethical and Organisational Aspects of Health Care in Prisons, Council [Council of Europe: April 1998]
- UN/OHCHR International Guidelines on HIV/AIDS and Human Rights [1998]
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty [1990]
- World Medical Association Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases [October 2000]
- Prison, Drugs and Society: A consensus Statement on Principles, Policies and Practices [WHO Europe/Pompidou Group of the Council of Europe: September 2001]
- UN Committee on Economic, Social, and Cultural Rights: General Comment on The right to the highest attainable standard of health. Twenty-second session, Geneva [2002]

- [International Guidelines on HIV-AIDS and Human Rights - Revised Guidelines 6, on access to prevention, treatment, care and support](#) [2002]
- International Labour Office Code of Practice on HIV/AIDS and the World of Work [2002]
- Moscow Declaration: Prison Health as part of Public Health [WHO Europe: October 2003]
- Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia [February 2004]
- Policy Brief: Reduction of HIV Transmission in Prisons [WHO/UNAIDS: 2004]
- Policy Statement on HIV Testing [UNAIDS/WHO: 2004]
- Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention [WHO/UNODC/UNAIDS: 2004]
- Status Paper on Prisons, Drugs and Harm Reduction Health (WHO Europe: May 2007)
- Health in Prisons: A WHO guide to the essentials in prison health (WHO Europe: May 2007).

### **Universal Declaration of Human Rights**

The Universal Declaration of Human Rights was adopted by the United Nations General Assembly in December 1948. Although not a legally binding document, it serves as the foundation for the original two legally-binding UN Human Rights Covenants, the [International Covenant on Civil and Political Rights](#), and the [International Covenant on Economic, Social, and Cultural Rights](#).

### **Standard Minimum Rules for the Treatment of Prisoners**

The UN Standard Minimum Rules for the Treatment of Prisoners were adopted by the first United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955, and approved by UN Economic and Social Council in 1957. This international document contains what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions. Part I of the rules covers the general management of institutions, and is applicable to all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to "security measures" or corrective measures ordered by the judge. Part II contains rules applicable only to the special categories dealt with in each section. It should be highlighted that although the Standard Minimum Rules are not a Treaty, they constitute an authoritative guide to binding treaty standards

[http://www.unhchr.ch/html/menu3/b/h\\_comp34.htm](http://www.unhchr.ch/html/menu3/b/h_comp34.htm)

### **International Covenant on Civil and Political Rights**

The International Covenant on Civil and Political Rights (ICCPR) entered into force on 23 March 1976. It is the most important human rights treaty in the world and it is of universal relevance. It is a legally binding document that requires Governments to ensure the respect of individual fundamental rights, including the right not to be subjected to torture or cruel, inhuman or degrading treatment or punishment (Article 7), the right of any detained person to be treated with humanity and with respect for their inherent dignity (Article 10), the right to privacy without arbitrary interference (Article 17). The ICCPR also recognizes that all people are equal before the law and are entitled to equal and effective protection against discrimination on grounds such as sex and race (Article 26).

<http://www1.umn.edu/humanrts/instree/b3ccpr.htm>

### **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment entered into force on 26 June 1987. It prohibits torture and cruel, inhuman, or degrading treatment or punishment, without exception or derogation. It establishes the Committee against Torture (CAT) and sets out the rules on its membership and activities.

[http://www.unhchr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhchr.ch/html/menu3/b/h_cat39.htm)

### **Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment**

This document was adopted by General Assembly resolution 43/173 in 1988. It set out the principles that should be applied for the protection of all persons under any form of detention or imprisonment. It consists of 39 principles. According to this instrument all the above mentioned persons shall be treated in a human manner and with respect of dignity. It also prohibits the torture or cruel, inhuman or degrading treatment or punishment and doesn't leave the space for any derogation.

[http://www.unhchr.ch/html/menu3/b/h\\_comp36.htm](http://www.unhchr.ch/html/menu3/b/h_comp36.htm)

### **Basic Principles for the Treatment of Prisoners**

This document was adopted by the General Assembly resolution 45/111 in 1990. It clearly reaffirms the tenet that prisoners retain fundamental human rights. It declares that "Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human

rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants." The Basic Principles for the Treatment of Prisoners is binding for governments to the extent that the norms set out explicate the broader standards contained in human rights treaties.

[http://www.unhchr.ch/html/menu3/b/h\\_comp35.htm](http://www.unhchr.ch/html/menu3/b/h_comp35.htm)

### **WHO guidelines on HIV infection and AIDS in prisons**

These guidelines were prepared on the basis of technical advice provided to WHO prior to and during a consultation of experts convened in Geneva in September 1992. The consultation included representatives of international and nongovernmental organizations and government departments with a wide range of experience and background in the health, management, and human rights aspects of HIV/AIDS in prisons. The guidelines provide standards - from a public health perspective - which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS. It is expected that the guidelines be adapted by prison authorities to meet their local needs

<http://www.ceehrn.org/EasyCEE/sys/files/WHO%20guidelines%20on%20HIV%20and%20AIDS%20in%20prison.pdf>

### **Moscow Declaration: Prison Health as part of Public Health**

The Moscow Declaration was adopted at the joint World Health Organization/Russian Federation International Meeting on Prison Health and Public Health, held in Moscow in October 2003. It states that penitentiary health must be an integral part of the public health system of any country and highlights that, it is necessary for both prison health and public health to bear equal responsibility for health in prisons. It further states that public and penitentiary health systems are recommended to work together to ensure that harm reduction becomes the guiding principle of policy on the prevention of HIV/AIDS and hepatitis transmission in penitentiary systems.

[http://www.hipp-europe.org/NEWS/moscow\\_declaration\\_eng04.pdf](http://www.hipp-europe.org/NEWS/moscow_declaration_eng04.pdf)

## **Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia**

The Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia, was released in Dublin, Ireland, on 23 February 2004 during the conference 'Breaking the Barriers: Partnership in the fight against HIV/AIDS in Europe and Central Asia'. It outlines an international consensus on the rights of prisoners to HIV prevention and treatment and the responsibility of governments to meet these agreed standards. It also provides a framework for action to address the prison HIV crisis based upon best practice, scientific evidence and human rights. The Dublin Declaration is endorsed by over 90 NGOs and experts from more than 20 countries including the Belarus, Belgium, Bulgaria, Canada, the Czech Republic, France, Germany, Ireland, Kazakhstan, Lithuania, Luxembourg, Moldova, the Netherlands, Portugal, Romania, Russia, Slovakia, Spain, Switzerland, Turkey, Ukraine, the United Kingdom and the United States.

[http://www.drugpolicy.org/docUploads/dublin\\_declaration\\_2004.pdf#search='%27dublin%20declaration%20HIV%20in%20prison%27'](http://www.drugpolicy.org/docUploads/dublin_declaration_2004.pdf#search='%27dublin%20declaration%20HIV%20in%20prison%27')

## **WHO Evidence for Action Technical Papers on Effectiveness of Drug Dependent Treatment in Preventing HIV among Injecting Drug Users**

- Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users
- Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users - Evidence for action technical papers
- Evidence for Action on HIV/AIDS and Injecting Drug Use - 5 Policy Briefs
- Advocacy Guide: HIV/AIDS Prevention among Injecting Drug Users
- Effectiveness of Community-Based Outreach in Preventing HIV/AIDS among Injecting Drug Users - Evidence for action technical papers
- Training Guide for HIV Prevention Outreach to Injecting Drug Users - Workshop Manual

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Additional information can be found at:

[http://www.unodc.org/unodc/en/treatment\\_toolkit.html](http://www.unodc.org/unodc/en/treatment_toolkit.html)

<http://nida.nih.gov/PODAT/PODATindex.html>

<http://eata.org.uk/rehab.php>

[http://nta.nhs.uk/publications/documents/nta\\_treat\\_drug\\_misuse\\_evidence\\_effectiveness\\_2006\\_rb5.pdf](http://nta.nhs.uk/publications/documents/nta_treat_drug_misuse_evidence_effectiveness_2006_rb5.pdf)

[www.beckleyfoundation.org](http://www.beckleyfoundation.org)

## Appendix A

### Multi Agency Working and Partnership Working Policy

#### Policy Statement

Cranstoun Drug Services adopts a multi-disciplinary approach in our service provision. We recognise that protocols and working agreements are the foundation of good partnership working.

This policy outlines the core requirements for such protocols and working agreements when working in a multi agency context.

#### Legislative Framework and Guidance

- Nil

#### Related Policies

- Confidentiality Policy
- Criminal Justice Work Protocol Policy
- Model of Service Delivery Policy

#### Policy

Protocols form the basis of Cranstoun Drug Services agreement with partner agencies regarding joint working and provide clarity on the expectations of each party.

Protocols will be required as appropriate (based on local need) in work for example with:

- Probation;
- Police;
- DIP Teams;
- Community Drug and Alcohol Services;
- Prison CARAT and Treatment Programmes;
- Community Safety Partnerships;
- Community Groups;
- Community Centres where Satellite Services are provided;
- Counselling Services.

All Cranstoun services are required to ensure that they have locally agreed protocols in place which comply with this policy document.

All locally agreed protocols must be authorised by the Area Manager.

**Essential requirements governing all aspects of joint / partnership working by Cranstoun services to be detailed (as appropriate) within the protocol include:**

- Regular liaison meetings (quarterly as a minimum) to be held to discuss specific areas of practice and casework between partner agencies. These meetings should be attended as a minimum by Service Managers and designated workers;
- The protocol should detail the respective remits and areas of work as agreed between both partners, this may include for example referral pathways and criteria for entry to and exclusion from the service;
- Partner agencies to be included on consent to liaise documentation. Confidentiality will be explained to all service users, this includes the limits placed on confidentiality and the need for the sharing of information within the team and between partner agencies. Where consent to liaise is declined the service user will be informed of the limits that this will place on the service that Cranstoun staff are able to offer;
- Following referral and subsequent assessment the outcome of the assessment will be relayed to the referrer;
- All referrals, communications and contacts will be logged. Information on attendance / non attendance will be reported as appropriate;
- Information on progress will be reported in terms that are sufficiently specific to ensure that the case manager is able to continue supervising, monitoring and supporting the service user following contact with Cranstoun services;
- Consent will be required from service users for information to be relayed to partner agency staff. In the context of provision of services in a criminal justice setting reference should be made to Cranstoun's Confidentiality Policy and Criminal Justice Work Protocol;
- Where either party has concerns regarding professional practice issues these should first be raised by the individual with their line manager through the line management process and supervision;
- Should the line manager agree that a professional practice issue exists this will be raised with the partner agency line manager;
- Where it is not possible or appropriate to raise the issue informally the External Complaints Policy should be followed;
- Where appropriate joint supervision arrangements should be agreed where Cranstoun staff co work with staff from partner agencies e.g. groupwork.

Clarification of this policy and further guidance can be provided by the Quality and Performance Directorate and / or the Area Manager.

## Appendix B

### Service Users Rights Policy

#### Policy Statement

Cranstoun Drug Services is committed to providing services of the highest quality to our service users. We believe that our service users have a right to the best service that our resources allow.

In their dealings with Cranstoun Drug Services service users have the right to confidentiality, to be treated with respect and to make a complaint. Service users will be informed of these rights on first contact and provided with a copy of our Service Users Rights Information Leaflet. Additionally all services will display Cranstoun's statement on service user rights in a visible and accessible location in services.

#### Legislative Framework and Guidance

- Nil

#### Related Policies

- Confidentiality Policy
- Diversity Policy
- Service User Complaints Procedure
- Equal Opportunities Policy

#### Policy

All service users have a right to confidentiality. Issues relating to confidentiality are detailed in Cranstoun's Confidentiality Policy.

It is an expectation that Cranstoun's Confidentiality Policy will be explained on first contact with all service users. The information should be explained fully and in a way that is understood by the service user, it is staff's responsibility to ensure that service users understand what is being explained to them. A copy of the Service Users Information Statement must be provided. These actions must be recorded in the client file.

Services must display Cranstoun's Statement on Service User Rights in a visible and accessible location in all service premises including CDA's, mobile needle exchange vans and satellite venues where appropriate.

All service users have the right to be treated with respect and to receive a service that addresses their diversity issues. Cranstoun will not tolerate any discrimination against service users on any grounds, particularly service user's gender, race, sexual orientation, offence, religion, disability, class or HIV status. Our policy is outlined in more detail in our Equal Opportunities and Diversity Policy.

Service Users will also be provided with opportunities to give feedback about the way we work and the services we provide. See Service User Feedback Policy. All services must provide opportunities for feedback at the close of service contact and at regular intervals.

Service users have the right to make a complaint. Minor complaints or concerns about our services should be discussed with the service user's key worker. If the service user is unhappy with their response, or the complaint is more serious the service user has the right to contact the Services Manager. The Services Manager must respond to the service user quickly. If the service user is unhappy with the Service Managers response, they may ask for a review. This policy is outlined in more detail in the Service Users Complaints Policy.

## Appendix C

### Service Users Complaints Policy

#### Policy Statement

Cranstoun Drug Services is committed to providing the best possible service and highest levels of care for our service users. We hope that service users will not have any cause for complaint concerning the nature or quality of our service. We will respond to any complaints or concerns raised by service users in a positive way and try to resolve them as quickly as possible.

Cranstoun is committed to service user rights and the right of our service users to provide feedback and where necessary make formal complaints.

#### Legislative Framework and Guidance

- Nil

#### Related Policies

- Service User Rights Policy

#### Policy

Given that complaints may range from minor problems to very serious issues, a flexible procedure has been designed in order to resolve problems as quickly as possible. The procedure also seeks to ensure that complaints are taken seriously and to protect service user's rights, ensuring that no-one has to suffer any situation where those rights are abused.

Before using the formal procedure service users are encouraged to attempt to resolve any problems through informal discussion with a member of staff. However, if a service user does not feel that this is appropriate or if they are dissatisfied with the outcome they have the right to enter into the complaint procedure.

Service users, have the right to make a complaint about any thing which they find unsatisfactory, unjust, offensive or discriminatory. This may concern the behaviour or another service user, a member of staff, a visitor or any incident or situation that disturbs or upsets them.

Cranstoun staff have a responsibility to provide help and support to service users. Staff and services must ensure that service users are aware of how

they can make a complaint, provide clarification on the process and offer support and assistance to service users in voicing their concerns.

Service Users are entitled at any stage, to use an advocate to help them to discuss their problem with Cranstoun. The advocate may accompany the service user to any necessary meetings. The advocate may be a friend, a relative, or another service user.

Any complaint made will be dealt with in confidence and where possible any action taken will be confidential to those concerned.

Service users always have access to external channels for making a complaint. Where a complaint is made by a service user to an external source, on receipt of the complaint this matter will be dealt with following the procedure outlined from stage 2.

All services will display the procedure for making a complaint in a visible and accessible location.

A copy of this policy must be provided on request to a service user or their advocate.

### **1. Procedure for making a complaint**

#### *Stage 1*

If a service user has cause for complaint they should contact their Project / Key Worker and arrange a meeting to discuss the problem. If this is not appropriate they should contact the Team Leader / Services Manager. Where a service user feels unable to discuss their complaint with the staff of the project, they should bring the matter to the attention of the next line manager or Area Manager.

The staff member to whom the complaint was made will meet with the service user as soon as possible (within three working days) to discuss the complaint. The outcome of the meeting will be sent to the service user in writing within five working days. The service user will be notified of any exceptions to this in writing.

At this stage the service user should decide whether they are satisfied with the result of the discussion and the action to be taken. If they are not satisfied, they should proceed to Stage 2.

### *Stage 2*

A letter outlining your complaint should be sent to the line manager of the person to whom the complaint was made.

A meeting will be held within ten working days to discuss the complaint with you. The outcome of the meeting will be sent to the service user in writing within ten working days. The service user will be notified of any exceptions to this in writing.

The service user should now decide whether they are satisfied with the result of the discussion and the action to be taken. If they are not satisfied, they can appeal for further consideration of the complaint at a final panel stage

### *Final Stage*

The Director of Quality and Performance should be notified in writing that a further appeal is required. The Director of Quality and Performance will investigate the service user's complaint and respond directly to the service users. The Director of Quality and Performance sits outside of operational line management and has an organisational lead on quality, interventions and clinical issues. If the service user is still unsatisfied they may request to meet with the Chief Executive and a member of the Board. This is the final stage of the internal complaints procedure.

A letter will be sent to the service user explaining this process. The meetings will be held within 14 days, and the decisions communicated within 21 days.

The Chief Executive and Boards decision is final.

## Appendix D

### Relapse Policy - Abstinence Based Services

#### Policy Statement

This policies applies to services where the service user agree to participate in a programme that requires abstinence e.g. residential services, community tier 3 structured programmes. In such situations service users will be required to agree to a programme of voluntary testing and will sign a compact to this effect.

Cranstoun Drug Services recognise that lapse and relapse can form part of the process of change and may occur during an otherwise 'successful' detoxification or treatment programme. We recognise that it is essential that service users are supported in their efforts to address their substance use, and that our services help service users normalise and manage, both change and relapse.

Cranstoun also recognises its obligation to provide a safe and drug free therapeutic environment in which staff and service users can work together.

In abstinence-based programmes and services our aim is to support service users in achieving a drug free status during their time on the programme. Service users will only be removed from the programme / service in cases of ongoing relapse.

#### Legislative Framework and Guidance

- Nil

#### Related Policies

- Confidentiality Policy
- Drug Testing of Service Users Policy
- Service User Rights Policy
- Recording of Information Policy

#### Policy

Where programmes and services require abstinence, all service users must agree to participate in a programme of voluntary urine testing as part of the programme. Each service will be required to sign a compact to this effect.

This policy provides guidance for services on a number of potential situations relating to relapse and positive drug tests.

#### 1. Suspected drug use

Where a service user appears to be affected by drug / alcohol use this matter should be discussed by the staff team as soon as possible and a drug test requested.

Where the drug use is denied but a positive test sample is produced by the service user, a member of staff will clarify whether there is any possibility that the positive result could be caused by prescribed medication. If no medication given fits the criteria for the positive test indicated a first written warning will be issued. This warning will outline the basic facts pertaining to the situation and will inform the service user that one more similar incident will result in suspension or termination of their participation on the programme.

If a service appears affected and acknowledges his / her drug / alcohol use a drug test will be requested by a staff member. If a positive urine sample is provided, the matter will be discussed with the Service Manager and the individual's keyworker. Such circumstances would not usually result in a warning. A second positive test would result in a warning.

#### 2. Positive Test

Where a service user admits to using / drinking or has initially had a positive test on arrival at the programme, the service user will be required to produce a number of samples in the first week following this initial positive result. Further samples will be requested in the second week all of which must be negative. If a positive urine sample is recorded in the second week, a written warning will be issued. A further positive sample would result in removal from the programme.

#### 3. Refusal to Provide a Sample

This is a breach of the compact and will result in automatic exclusion from the programme. A sample provided after the time allocated should also be considered to be a refusal and treated similarly unless there are extenuating circumstances.

#### 4. Tampered samples

Tampered samples will be viewed as positive test results. In the event of a urine sample being judged to having been tampered with (e.g. diluted, mixed with some other substance or is cold), staff may request as many further samples as is necessary to gain a satisfactory test sample. Staff must raise any concerns with the Service Manager. A tampered sample must be dealt with in accordance to the policy relating to a positive test result.

#### 5. Where a Service User is Unable to Provide a Sample

In the case of urine testing if a service user is unable to provide a urine sample during the time requested and is experiencing genuine difficulties in

providing a sample, he / she should be encouraged to drink fluids. A sample will then be requested every 20-30 minutes. If after 1.5 hours the service user states that he / she is still unable to urinate then this will be viewed as a refusal and dealt with as such resulting in possible exclusion from the programme.

Any decision or action in relation to any of the above must be made in conjunction and consultation with the Service Manager.

#### 6. Re-admission

Further applications to the programme from a service whose residency or participation in a programme is terminated under this policy will not be considered until a minimum period of 3 months since their departure date has elapsed.